



Review of Advocacy Services for Children and Adults in Northern Ireland

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The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting on three key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?

These stakeholder outcomes are aligned with Quality 2020,¹ and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

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We would particularly like to thank the Health and Social Care Board (HSC Board), the Health and Social Care trusts (HSC trusts) and independent advocacy providers for providing information to underpin the review process.

¹ Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - <http://www.dhsspsni.gov.uk/quality2020.pdf>

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Executive Summary

In May 2012, a guide for commissioners (Developing Advocacy Services) and an associated action plan were published by the Department of Health, Social Services and Public Safety (DHSSPS), to help commissioners better understand and develop advocacy services in Northern Ireland.²

The guide introduced principles and standards to underpin the future commissioning and delivery of all health and social care (HSC) advocacy services. It recognised these may need to be tailored to meet the needs of specific client groups.

As part of its 2015-18 review programme, RQIA was commissioned by DHSSPS to conduct a review of the commissioning arrangements for the provision of Advocacy Services for Children and Adults in Northern Ireland. The review examined the commissioning systems and processes to consider if they were in keeping with the principles and standards set out within the DHSSPS policy guide.

The Health and Social Care Board (HSC Board) is responsible for identifying the need for advocacy services for children and adults, and commissions some services directly through regional contracts. Health and Social Care trusts (HSC trusts) commission advocacy services from providers for their local populations.

RQIA found that the HSC Board and trusts have clear commissioning arrangements in place. Contracts reflect the principles and standards set out in the DHSSPS guide. The commissioning process adheres to relevant procurement of goods and services legislation. Feedback from independent advocacy providers highlighted that the process was considered to be consistent, fair and equitable.

RQIA was provided with examples which demonstrated that HSC organisations value the importance of independent advocacy services. Advocacy is now regarded as a core element of provision for some services, and is recognised to be valuable when service changes are being considered or implemented.

Following the publication of the guide and action plan, an implementation process was established by the HSC Board. The Advocacy Network for Northern Ireland (ANNI) facilitated the development of specific documents to support the implementation process.

² <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

RQIA identified a number of constraints that impact on the optimal delivery of advocacy services in Northern Ireland:

- At present there is no clear statutory duty or strategic framework to provide independent advocacy services in Northern Ireland.
- A lack of resources has impacted on investing in advocacy services across all programmes of care.
- There is no process for regulation of providers of advocacy services or for individuals undertaking advocacy.

RQIA found that the provision of advocacy services varies across geographical areas and HSC trust programmes of care (PoC). Most advocacy services are provided for mental health, learning disability, and family and children's services. In most HSC trusts, there is limited investment in advocacy for individuals in other PoC.

It is recognised by both commissioners and providers that the current contract arrangements for advocacy focus mainly on outputs in relation to how much activity is provided, rather than on outcomes. The contracting process does not fully reflect the complexities of the work of advocacy. The time spent on working with someone in a challenging situation where they need advocacy can be substantial. Each case is different and may require contact with a range of organisations.

RQIA was advised that it is anticipated that the future direction of advocacy services will be impacted by the new mental capacity legislation and potential new European procurement legislation, and this will need to be assessed.

RQIA makes eight recommendations for improvements in the commissioning process and quality of advocacy services for children and adults in Northern Ireland.

The recommendations have been prioritised in relation to the timescales in which they should be implemented:

- Priority 1 – to be completed within 6 months of publication of report
- Priority 2 – to be completed within 12 months of publication of report
- Priority 3 – to be completed within 18 months of publication of report

Chapter 1: Introduction

1.1 Introduction

The DHSSPS policy guide, Developing Advocacy Services³ was developed by a working group, established in June 2010, and chaired by the Chief Executive of the Patient and Client Council (PCC). The group was established in response to recommendations in the Bamford Review report on Human Rights and Equality of Opportunity in relation to advocacy.⁴

The guide aims to inform the commissioning and provision of advocacy services in a HSC setting for people who require advocacy support. This includes people who are living with disabilities – physical, sensory, mental, learning or communication related. It may also include others such as carers, children and young people, older people, victims, and prisoners.

The guide was also informed by a scoping study carried out by the DHSSPS in May 2010.⁵ The study gathered information on advocacy services, commissioned or provided by the HSC Board and trusts, for people aged 16 and over with mental health conditions; learning disabilities; physical and sensory disabilities; and older people (focusing on those with dementia).

A diverse range of client groups and users may require advocacy. It was recognised that aspects of the guide, in particular, the commissioning and delivery of the principles and standards, may require to be tailored to meet their specific needs.

Definition and Models of Independent Advocacy

Independent advocacy plays a crucial role for service users and carers. It can support people who use HSC services to: articulate their views and wishes; secure their rights; have their interests represented; and influence the services they receive to reflect their own interests and preferences.

Independent advocacy can mean different things to different people in different contexts. However, the following descriptions reflect the role of advocacy in a HSC context:

“Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people.” (Bamford Review Report on Human Rights and Equality of Opportunity)⁶

³ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

⁴ www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf

⁵ Scoping study, research and workshop summary papers can be viewed at http://www.dhsspsni.gov.uk/show_publications?txtid=47432

⁶ http://www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf

“Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and justice.”
(Advocacy Charter produced by Action for Advocacy)⁷

“Advocacy is the process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up for justice.”
(The Scottish Independent Advocacy Alliance: Principles and Standards for Independent Advocacy)⁸

Advocacy can empower people to speak up for themselves. It can also help people to become more aware of their rights, to exercise those rights and to be involved in and influence decisions that are being made about their care, treatment or support.⁹

In certain situations, however, people in need of support may be unable to clearly articulate or express their views. Such cases can be particularly challenging, and highlight the vital role that advocacy can play in securing a person’s rights, representing their interests and ensuring that decisions are taken with due regard to their preferences or perspectives. This type of advocacy is often referred to as non-instructed advocacy.¹⁰

The most common types or models of advocacy are:¹¹

Citizen Advocacy

Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who may need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long-term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the organisation providing the advocacy service. The advocate supports their partner using their natural skills and talents, rather than being trained in the role.

Self/Group Advocacy

Self-advocacy, speaking up for yourself, is the ultimate aim of most advocacy. Where self-advocates come together, this is often referred to as group or collective. Group advocacy happens where a group of people who are all facing a common problem get together on a formal basis to support each other over specific issues. Individual members of the group may also support

⁷ <http://www.qualityadvocacy.org.uk/wp-content/uploads/2014/03/Code-of-Practice.pdf>

⁸ http://www.siaa.org.uk/wp-content/uploads/2013/11/siaa_principles_and_standards_2010.pdf

⁹ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

¹⁰ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

¹¹ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

each other over specific issues. The group as a whole may campaign on an issue that affects them all. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual's sense of isolation when raising a difficult issue.

Peer Advocacy

Peer advocacy happens when individuals share significant life experiences. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and empathise with their advocacy partner. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

Issue-based Advocacy

Issue-based advocacy is also known as one-to-one, individual or professional advocacy. It is provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

Non-instructed Advocacy

Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity, for example, comprehension or communication issues. An individual might be able to express what they want, for example, to go home or a view of what they like or dislike, but may lack the capacity to instruct an advocate as to the action to take regarding a particular issue. The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.

Going forward, it is essential that commissioners are aware of, and understand the role that advocacy can play in helping to achieve the priorities that have been set for HSC in Northern Ireland, and in supporting the proposed model for the future delivery set out in Transforming Your Care (TYC).¹²

¹² www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

1.2 Context of the Review

Advocacy services for both children and adults have been considered in recent reviews and strategies both in Northern Ireland and elsewhere in the United Kingdom.

Northern Ireland

The DHSSPS has published HSC service frameworks for key services including, mental health, learning disability, and older people.¹³ Service frameworks set out, at high level, standards for services which patients and users should expect to receive. Each framework has high level standards in relation to advocacy which state:

“Service users and their carers should have access to independent advocacy as required”.

Delivering the Bamford Vision action plan 2012-15 included the implementation of mental capacity legislation. The Mental Capacity Bill includes a consistent approach, with appropriate safeguards to decisions about care, treatment, property or assets, which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reasons.¹⁴ In particular, the Bill will provide for the appointment of independent advocates. An independent advocate under the Bill will be a person who can speak on behalf of a person who lacks capacity and who will have knowledge of the procedures involved in relation to a proposed intervention, and of the person’s rights under the Bill, in particular the person’s right to seek review of any authorisation. The primary role of the independent advocate under the Bill is to support and represent the person who lacks capacity in the determination of whether a proposed act is in his or her best interest.

RQIA has published a number of reports which reflect the value and importance of advocacy services, and a key way of supporting people to access appropriate services and allow them to participate in decisions about their life.

In March 2012, RQIA published the report of a review of the Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland.¹⁵ This review concluded that there was a significant amount of work to be done with regard to ongoing policy development relating to advocacy. This included implementing the administrative procedures required to support the independent advocate role and in signposting patients to the most appropriate advocacy service to best meet their needs.

¹³ <http://www.dhsspsni.gov.uk/sqsd-standards-service-frameworks>

¹⁴ <https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf>

¹⁵ http://rqia.org.uk/cms_resources/Advocacy_Report_final%20report.pdf

In October 2012, RQIA published the report of a review of the implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (May 2010).¹⁶ The review provided evidence of positive developments by HSC trusts in relation to advocacy services.

In February 2013, RQIA published the report of a review of Safeguarding Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland.¹⁷ This review recommended that HSC trusts should ensure that patients and relatives on all wards have access to advocacy services.

England and Wales

The Royal College of Psychiatrists (RCPsych) published a report in February 2012 on 'Independent advocacy for people with mental disorder'. This highlighted that in England and Wales there is an independent mental capacity advocacy service for those who lack the capacity to make decisions for themselves, a situation which is not uncommon in general hospitals. The report stated that staff in general hospitals will usually be less aware of the need for advocacy services and indeed of their role, and psychiatrists and other mental health staff had a part to play in addressing this.¹⁸

In March 2015, the Department of Health (DOH) published the 'Analysis of the use of the IMCA (Independent Mental Capacity Advocacy) Service in England from April 2013 to March 2014'. It identified patterns and trends in the use of independent mental capacity advocates, and where more can be done so that everyone entitled to advocacy has access to it.¹⁹

A review undertaken by the National Institute for Health Research (NIHR) concluded the lack of robust evidence leaves advocacy in a potentially vulnerable position, and the need for better quality, more widely quantified information on the outcomes of advocacy has never been greater.²⁰

The National Institute for Health and Care Excellence (NICE) published specific standards in relation to advocacy services. NICE quality standard (QS30), states: "people with dementia are enabled, with the involvement of their carers, to access independent advocacy services".²¹

The Welsh Government in December 2011 published the 'Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Planners'. This reinforced the importance of certain

¹⁶http://www.rqia.org.uk/cms_resources/PQC%20Overview%20Report%20Final%20October%202012.pdf

¹⁷http://www.rqia.org.uk/cms_resources/Overview%20Report%20of%20Safeguarding%20in%20MHL%20Hospitals%2014%20Feb%2013_ISBN.pdf

¹⁸http://www.mentalhealthlaw.co.uk/media/RCPsych_CR171_Independent_Advocacy.pdf

¹⁹ <https://www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-7th-annual-report>

²⁰ <http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SR7.pdf>

²¹ <https://www.nice.org.uk/guidance/qs30/chapter/quality-statement-9-independent-advocacy>

principles, and also the need for independent mental health advocacy services to recognise they are delivering a statutorily required function.²²

Scotland

In 2013, Scotland published revised guidance for advocacy which aimed to capture developments since the publication of a Guide to Commissioners in 2001 by the then Scottish Executive Health Department. It sought to clarify commissioners' statutory responsibilities under the Mental Health (Care & Treatment) (Scotland) Act 2003.²³

Existing Provision in Northern Ireland

Following the publication of the DHSSPS action plan, the HSC Board undertook a scoping exercise in 2012-13, which highlighted that most advocacy services do not fit neatly into programmes of care or across geographical structures.

In addition, there were a number of factors driving the need for this review. Firstly, there is a need for greater parity and consistency in relation to the commissioning and delivery of advocacy services in a HSC setting in Northern Ireland. Currently, there is an array of advocacy services being provided by a range of mainly community and voluntary organisations and groups, which receive funding from a variety of sources, including the statutory sector. As a result, a wealth of experience and skills has already been built up.

However, in terms of what is commissioned by the statutory sector, existing provision is patchy, with some HSC trusts having more established arrangements in place than others.

Investing in advocacy means that people who are vulnerable or at risk of exclusion or being discriminated against have a vehicle through which they can have their voice heard, gain access to information to help them make informed choices about their health and wellbeing and have their rights secured. Advocacy empowers people and can also help to safeguard people.²⁴

Investing in advocacy services not only benefits the person needing support. It can also benefit commissioners and providers of HSC services. For example, advocacy can help prevent crises arising in a person's life which otherwise may result in an intervention that has much greater resource implications. It can also enhance capacity building at a community and individual level which can ultimately serve to reduce dependency on other HSC services.²⁵

²² <https://www.rcpsych.ac.uk/pdf/Advocacy%20Guidance.pdf>

²³ <http://www.gov.scot/Publications/2013/12/7000>

²⁴ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

²⁵ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

Effective advocacy services have the potential to contribute to a number of strategic priorities for HSC that ultimately promote wider equality and human rights objectives. The support that advocates provide can help people avail of opportunities and exercise rights to which they are entitled. This not only has the potential to enhance their daily lives but it can also help to build their confidence and capacity to play an active role in society and secure greater equality in service provision generally.²⁶

As part of its 2015-18 review programme, RQIA was commissioned by the DHSSPS to carry out this review, to gain assurance as to the effectiveness of the existing commissioning processes undertaken by the HSC Board and trusts.

1.3 Background

Roles and Responsibilities

Health and Social Care Board

The HSC Board advised RQIA that its main role is to identify the needs of the Northern Ireland population and to commission HSC services to meet those needs, within the strategic priorities identified by the DHSSPS and the funding made available. Where independent advocacy is the most appropriate service to meet an identified need or strategic objective, and funds are available, the HSC Board will commission that type of service.

The HSC Board currently has a number of regional contracts to deliver independent advocacy across different programmes of care including, children services, people with hearing impairment, and children with disabilities. The HSC Board also commissions advocacy in relation to resettlement of learning disability patients from hospital.

In September 2012, the HSC Board established an Advocacy Commissioning Group which involved representatives from the five local commissioning groups (LCGs) and five HSC trusts. This group agreed terms of reference and operated until December 2013, when it was deemed that the major objectives of the group had been achieved.

The HSC Board also established an internal advocacy group, and currently employs four social care commissioning leads, responsible for taking forward the action plan associated with the DHSSPS policy guide. The role and remit of the group is to support the service improvements identified in the action plan as they apply to independent advocacy services for people with serious mental illness, learning disability, children's services, older people and physical disability.

²⁶ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

Health and Social Care Trusts

The five HSC trusts have responsibility for commissioning advocacy services from independent advocacy providers. These are commissioned through a tendering process, adhering to the DHSSPS policy guide and procurement legislation.

Advocacy services are commissioned across various programmes of care, primarily within:

- family and child care
- children and adult learning disability
- children and adult mental health
- adult physical disability

HSC trusts advised RQIA that specific advocacy services for conditions such as dementia and autism are commissioned on a short-term basis, as and when required.

Independent Advocacy Providers

Independent advocacy providers are responsible for the delivery of the advocacy services for which they have agreed contracts in place with either the HSC Board or trusts. Advocacy providers may focus on provision of services to individuals in a specific PoC, or across PoCs.

Independent advocacy providers are supported by the HSC Board and individual trusts to work in specific services and localities, engaging with patients, service users and carers in both acute and community settings.

Providers also engage with the HSC Board and individual trusts through attending regular management, policy, service delivery, and budgetary meetings.

The independence of the role of the advocacy providers is considered as key to delivering support to people who use HSC services to articulate their views and wishes; secure their rights; have their interests represented and influence the services they receive, to reflect their own interests and preferences.

Information about the delivery of advocacy services is provided to the contracting authority (HSC Board/HSC trust) via monthly monitoring return forms, which collect data in relation to the volumes of services being delivered. However, the monitoring arrangements do not capture the quality of the advocacy service provided or the outcomes of individual cases.

Throughout the year independent advocacy services provide feedback from their experiences and lessons learnt to the contracting authority.

The Northern Ireland Commissioner for Children and Young People (NICCY), and Commissioner for Older People (COPNI) are independent voices and champions for children, young people, and older people across Northern Ireland, standing up and speaking out on their behalf. They work to ensure that those who are vulnerable and at risk are kept safe and ensures that all

children, young people, and older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services they need.

Advocacy Network for Northern Ireland

The Advocacy Network for Northern Ireland, ANNI, was established in August 2012, with the aim of providing opportunities for independent advocacy organisations to:

- share expertise, best practice and experience
- provide shared training and development opportunities
- promote independent advocacy
- identify and follow up opportunities to develop the advocacy services sector

The HSC Board has worked with ANNI from its inaugural meeting, as a means of engaging with the advocacy sector. This relationship led to ANNI being commissioned to develop a code of practice for independent advocates, along with a standards framework and a core induction checklist. The HSC Board provided funding and a project manager was appointed to coordinate the work of ANNI. The funding provided to ANNI was on a non-recurrent basis for a defined time period.

Advocacy Commissioning Structure / Process

The procurement of goods and services for the HSC Board and trusts is managed and delivered by the Procurement and Logistics Service (PaLS), which is accredited as a Centre of Procurement Expertise (CoPEs).

PaLS is part of the Business Services Organisation (BSO) which provides a broad range of regional business support functions and specialist professional services to the whole of the HSC sector in Northern Ireland.

During the commissioning process for independent advocacy services, the HSC Board and trusts adhere to the Northern Ireland Public Procurement Policy Handbook (June 2011),²⁷ and the European Union Treaty Principles. The HSC Board and trusts also adhere to DHSSPS Procurement Guidance Notes,²⁸ and 'Management of Purchasing and Supply' guidance (mini-code),²⁹ which allows for local competition at the lower level spend moving to European Union (EU) competition on the appropriate higher level spend.

²⁷ <http://www.hscbusiness.hscni.net/pdf/ni-ppp-handbook-v3-june-2011.pdf>

²⁸ http://www.dfpni.gov.uk/index/procurement-2/cpd/cpd-policy-and-legislation/content_cpd_policy_procurement_guidance_notes/content_cpd_policy_pgn_05_14_collaborative_procurement/pgn_05_14_v2_collaborative_procurement.pdf

²⁹ <http://www.dhsspsni.gov.uk/cas-purchasing.pdf>

Fundamental principles from the EU Treaty which the HSC Board and HSC trust must adhere to include:

- transparency – contract procedures must be transparent and contract opportunities should generally be publicised
- equal treatment and non-discrimination – potential suppliers must be treated equally
- proportionality – procurement procedures and decisions must be proportionate
- mutual recognition – giving equal validity to qualifications and standards from other member states, where appropriate

The HSC Board and trusts receive advice and guidance from the Central Procurement Directorate within the Department of Finance and Personnel (DFP), and BSO Procurement Unit, when undertaking a tendering process.

A regional Social Care Procurement Group (SCPG) is in place and provides advice to the Regional Procurement Board on the direction of social care procurement. Members of the group are drawn from HSC trusts, HSC Board, Public Health Agency (PHA), and BSO. The SCPG is leading on development of proposals for an approach to social care procurement which will focus on increasing compliance in this sector.

A procurement strategy for HSC and arm's length bodies (ALBs) is currently being developed by the DHSSPS. This will set out key objectives and targets for continual improvement in the acquisition of goods, services and works. All bodies will be expected to implement all aspects of the strategy.

Currently, the HSC Board and trusts undergo tendering processes as contracts become due for renewal. Retendered contracts are generally for three years, with an option of an additional two year extension.

Appendix 1 sets out an example of the processes which the HSC Board and trusts follow when commissioning independent advocacy services for children and adults in Northern Ireland.

The Scoring System

The scoring system used by both the HSC Board and trusts when awarding contracts for the provision of independent advocacy services across Northern Ireland and Europe adhere to the follow two criteria.

1. Selection Criteria – This is scored on the historic and current information from the provider organisation in line with the DHSSPS policy guide. For example, is the provider organisation structurally independent? This information is scored pass or fail.

2. Award Criteria – This is weighted against four main areas. The first three areas are scored out of 60% and relate to the providers. The fourth area is price, and accounts for 40% of the overall scoring total of 100%:

1. Service delivery plan
2. Staff levels and training
3. Governance arrangements, policies and procedures, and service continuity plans
4. Price

RQIA found that most independent advocacy providers indicated that they are content with the current contract arrangements, and that the tendering process is consistent, fair and an appropriate quality method of commissioning.

1.4 Terms of Reference

The Terms of Reference of the Review:

1. To profile the current provision of advocacy services for all programmes of care across each HSC trust, and assess the impact of the guide on the range and quality of advocacy services currently available to service users and carers.
2. To assess the implementation of the policy guide and progress made in relation to its associated action plan (Developing Advocacy Services: A Policy Guide for Commissioners and its associated Action Plan, May 2012).
3. To evaluate the effectiveness of the processes HSC trusts have in place to gain assurance that the six commissioning principles are adhered to during their contract process.
4. To evaluate the effectiveness of the processes HSC trusts have in place to monitor the adherence of advocacy service providers to the proposed Principles and Standards.
5. To evaluate the effectiveness of the processes HSC trusts have in place to raise awareness of advocacy services, and the importance of independence, among health and social care professionals and service users and carers.
6. To consider the implications of the new mental capacity legislation on future provision of advocacy service in Northern Ireland.
7. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements in advocacy service provision in Northern Ireland.

1.5 Methodology

The review methodology was designed to gather information about the current processes and contracting arrangements in place to assure adherence to the DHSSPS policy guide and associated action plan for commissioners.

The methodology was as follows:

1. Literature search/review to determine relevant areas in relation to the provision of advocacy services for children and adults in Northern Ireland.
2. Discussions with the HSC Board, HSC trusts and Advocacy Network for Northern Ireland (ANNI).
3. Self-assessment questionnaire completed and returned by the HSC Board and HSC trusts.
4. Self-assessment questionnaire completed and returned by independent advocacy providers.
5. Meetings and telephone discussions with independent advocacy providers.
6. Regional summit event and group discussions involving all relevant stakeholders.
7. Publication of an overview report of the findings of the review.

Chapter 2: Findings

2.1 Profile of Advocacy Services for Children and Adults in Northern Ireland

Table 1 highlights the current profile of independent advocacy services commissioned by HSC services within Northern Ireland, on a local and regional level. It should be noted that some independent advocacy services are commissioned on a short-term, which are not reflected in the table.

Table 1: Current Profile of Independent Advocacy Services within Northern Ireland on a Local and Regional Level

Commissioning Organisation	Independent Advocacy Organisation	Programme of Care	Local or Regional Service
HSC Board	VOYPIC	Children and Young People, including CAMHS and Learning Disability	Regional
HSC Board	British Deaf Association	People with Hearing Problems	Regional
HSC Board	Barnardos	Children with Disabilities	Regional
HSC Board	Bryson Charitable Group	Learning Disability Resettlement	Regional
HSC Board	Mencap	Learning Disability Resettlement	Regional
Belfast Trust	Irish Advocacy Network	Adult Mental Health	Local
Belfast Trust	NIAMH	Adult Mental Health	Local
Belfast Trust	Mindwise	Adult Mental Health	Local
Belfast Trust	CAUSE	Adult Mental Health, Forensics, Carers	Local
Belfast Trust	Praxis	Adult Mental Health	Local
Belfast Trust	Bryson Charitable Group	Adult Learning Disability	Local
Belfast Trust	NIACRO	Children and Young People	Local
South Eastern Trust	NIACRO	Children and Young People	Local
South Eastern Trust	Mindwise	Adult Mental Health	Local
South Eastern Trust	CAUSE	Adult Mental Health	Local
South Eastern Trust	Telling It Like It Is (TILII Group)	Adult Learning Disability	Local
South Eastern Trust	Carers Forum Advocacy Group	Adult Learning Disability	Local

South Eastern Trust	Age NI	Older People	Local
South Eastern Trust	Alzheimer Society	Older People	Local
Western Trust	VOCAL	Adult Learning Disability	Local
Western Trust	Mind Yourself	Adult Mental Health	Local
Western Trust	Disability Action	Adult physical, sensory and autism services	Local
Southern Trust	NIAMH	Adult Mental Health (including older people and carers)	Local
Southern Trust	CAUSE	Adult Mental Health (including older people and carers)	Local
Southern Trust	Disability Action	Adult Learning Disability Resettlement	Local
Southern Trust	Disability Action	Adult physical, sensory and autism services	Local
Northern Trust	NIAMH	Adult Mental Health	Local
Northern Trust	Disability Action	Adult Learning Disability	Local
Northern Trust	Disability Action	Adult Physical Disability	Local

RQIA found that there is no regional information system in place to capture the full picture of the current profile of advocacy services in Northern Ireland. Workforce and workload varies across each independent advocacy organisation, which is heavily influenced by funding and type of contract.

RQIA was advised that the number of advocates employed by independent advocacy organisations ranges from 1 - 9 whole time equivalent (wte). Organisations advised that demand for advocacy services is increasing year on year.

Figures 1 and 2 show examples of increasing demand from two independent advocacy organisations.

Figure 1: VOYPIC - Children and Young People Advocacy Services

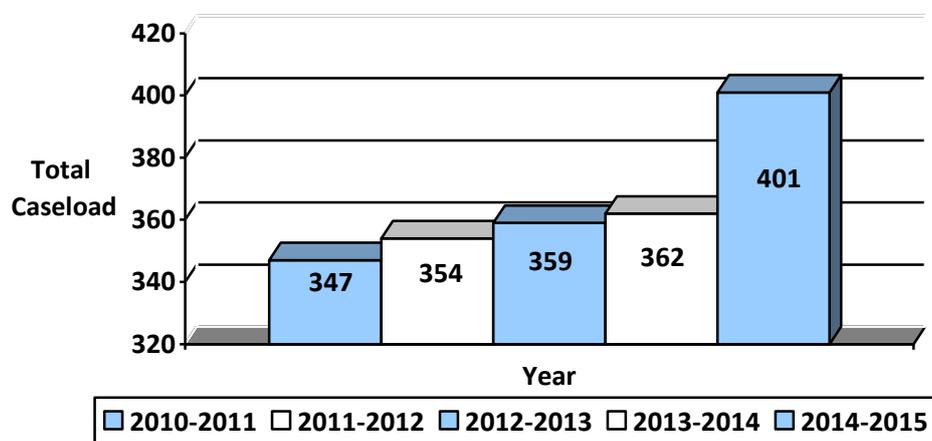
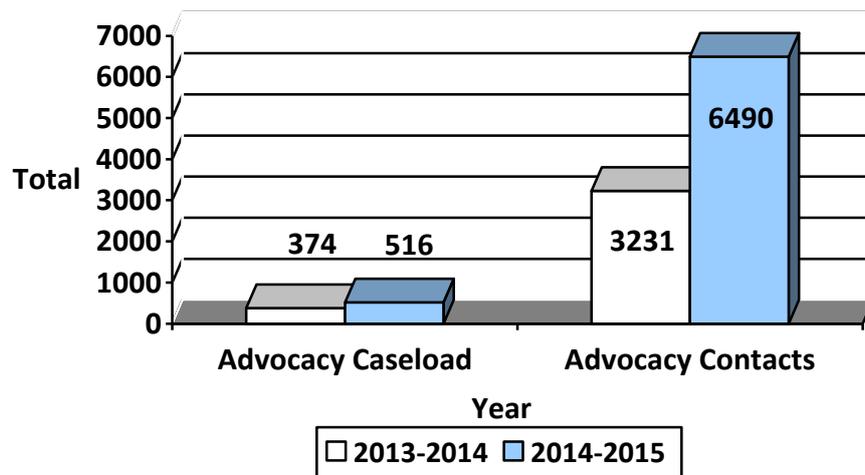


Figure 2: NIAMH - Adult Mental Health Advocacy Services



Information received from HSC organisations and independent advocacy providers highlighted that the current profile of advocacy services varies across geographical areas and across different PoC.

Information provided by HSC organisations indicated that most advocacy services are provided for individuals using adult mental health, adult learning disability, and family and children’s services.

HSC trusts advised that they commission advocacy services for other programmes including adult physical disability, sensory impaired and older people; or for people with specific conditions including Alzheimer’s disease, and autism. However, the pattern is not consistent across all HSC trusts.

On a regional level, the HSC Board directly commissions advocacy for children’s services; children with disabilities; resettlement of patients from hospital with a learning disability; and people with hearing problems.

RQIA found that most funding is used for professional advocacy, although many of the professional advocacy organisations also facilitate self/group, and peer advocacy services within the relevant HSC trust.

RQIA was advised that the number of service users, and complexity of cases, varies considerably across providers and HSC trusts. The review found that some cases can be resolved quickly over the telephone or by a single visit from the advocate. However, other cases can be very complex and lengthy, taking more than six months to resolve, and requiring a multidisciplinary approach to the casework.

Due to a lack of regional information available, the review team would recommend a needs assessment to determine future requirements, and assist in the development plans for future demands on advocacy services. With evidence of increasing demand, along with complex cases, the review team recommends that the capacity of advocacy services is reviewed to improve

access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.

Independent advocacy providers advised that some complex cases could require advocates to link with other sectors, including housing and education to assist their clients in resolving issues. RQIA was advised that there is no clear framework for this to occur.

During individual discussions with organisations and at the regional summit event, RQIA was advised that there is no regular forum through which learning about advocacy services is shared across the commissioners and providers of advocacy services. However, ANNI facilitates meetings for discussions between its member organisations.

Participants at the review summit event suggested other approaches such as newsletters or an annual regional event to share learning between providers and HSC organisations about the provision of advocacy services.

Recommendation 1	Priority 3
HSC trusts / Commissioners should carry out a needs assessment to determine future capacity requirements, and improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.	

Recommendation 2	Priority 3
HSC Board in partnership with relevant organisations should review and clarify arrangements for advocates to link with other sectors, including housing and education, when this is required in seeking to resolve cross-agency issues for their clients.	

Recommendation 3	Priority 2
HSC Board should work in partnership with HSC trusts and independent advocacy providers to consider other approaches such as newsletters or an annual event to share learning and experiences of advocacy services across organisations.	

2.2 Range and Quality of Advocacy Services since the Implementation of DHSSPS Policy Guide, May 2012

RQIA found that the range and quality of advocacy has improved in several areas since the implementation of the DHSSPS policy guide.

The review found that there is greater involvement and communication of advocates during the implementation of service changes, and HSC organisations now see advocacy as playing a key role in involving and supporting patients and clients in processes. For example, informing service policy and strategies such as the resettlement from long stay institutions.

The review also found improved continuity of care, with advocates enhancing their skill and expertise. For example, advocates undertaking accredited Open College Network (OCN) advocacy courses, such as Level 3 (Independent Advocacy Management) and Level 4 (Understanding Advocacy in a Capacity Context). Also, the DHSSPS Office of Social Services (OSS) has provided funding for training social care staff in the voluntary sector.

The review team was also provided with evidence of improved processes and mechanisms within HSC trusts and HSC Board to raise awareness, disseminate information, and evaluate advocacy services. For example, through the establishment of ANNI, the development of the code of practice, standards framework, and core induction checklist, was an important step in raising the standards, profile and professionalism of independent advocacy in Northern Ireland.

However, the review found that the range of provision of advocacy services has not substantially changed since the DHSSPS and the HSC Board completed scoping exercises in 2010-11 and 2012-13.

The provision of advocacy services continues to be predominately for mental health, learning disability and children's services. There have been some developments for other programmes of care, however, RQIA was advised that these vary in nature and extent across different areas. There are recognised gaps, for example, in the provision of advocacy for people with particular conditions such as brain injury.

While recognising significant developments in relation to training of advocates, there is a lack of consistency in this training. RQIA was advised that there will be significant resource and training implications to prepare for the implementation of the new mental capacity legislation.

Recommendation 4	Priority 3
The resource and training implications for advocacy services should be included in the assessment of requirements to take forward the implementation of the new mental capacity legislation.	

2.3 Implementation of the Policy Guide and Progress Made in Relation to the Associated Action Plan

The review team found that, before the implementation of the DHSSPS policy guide in May 2012, HSC organisations already had arrangements and processes in place for the commissioning of independent advocacy services. However, HSC organisations welcomed this policy guide, as it has ensured a more structured commissioning process and increased awareness of independent advocacy services across HSC organisations.

The HSC Board advised the review team of the processes involved in taking forward the associated action plan, aligned to the DHSSPS policy guide. The HSC Board highlighted that the implementation of the policy guide, and its associated action plan, was introduced without any additional resource. Therefore, actions had to be achieved within existing resources, and, in the absence of any formal accreditation or regulatory framework for advocacy services.

The HSC Board established the Advocacy Commissioning Group in September 2012, which included senior leads from the five LCGs and HSC Trusts. RQIA was advised that nominated members of this group changed throughout its lifetime. This group developed and agreed terms of reference to take forward the DHSSPS policy guide and associated action plan. The group stood down in December 2013, when the HSC Board considered that the major objectives of the group had been achieved.

The terms of reference for the Advocacy Commissioning Group:

1. Review and update the advocacy services scoping exercise concluded in 2010 to identify currently commissioned services that are consistent with the definitions presented in the DHSSPS policy guide.
2. Ensure the implementation of the advocacy commissioning principles within HSC contracting/commissioning organisations.
3. Support currently commissioned services to meet the principles and standards for advocacy services.
4. Facilitate and support efforts to raise the awareness of clinical, professional and managerial staff of the benefits of independent advocacy.

The Advocacy Commissioning Group worked in partnership with independent advocacy providers through ANNI to develop and agree the following products:

1. Code of practice for independent advocates.
2. Standards framework.
3. Core induction checklist.

The process also provided support to independent advocacy providers to review their compliance with the principles and standards set out in the DHSSPS policy guide, and to begin the process of improvement planning through self-assessment and audit.

RQIA found that the work done by the Advocacy Commissioning Group to implement the action plan had delivered on its agreed terms of reference.

However, when the group stood down, there was no longer a regional forum to discuss advocacy issues across organisations.

2.4 The Commissioning Principles

The Commissioning Framework for Health and Social Care³⁰ sets out principles governing the contractual relationship between commissioners and service providers of advocacy services. The principles are aimed at ensuring that commissioners choose only good quality advocacy services. They apply regardless of the type or model of advocacy being commissioned.

RQIA found that the HSC Board and trusts have effective commissioning arrangements in place, and that the HSC Board and trusts seek to reflect the commissioning principles when awarding contracts.

The HSC Board and trusts highlighted that their commissioning processes are guided by experienced procurement officers, supporting senior managers to develop a service specification. Prospective independent advocacy providers are asked to submit proposals to provide services which can meet the requirements of the service specifications.

The service specifications set out clear quality standards which the HSC Board and trusts expect from independent advocacy providers. During the tendering process, the HSC Board and trusts use a scoring system which will reject applications if they cannot demonstrate that they can adhere to the six commissioning principles. For example, the tendering process dictates that only those who are structurally independent from all statutory organisations and preferably from service providers can compete for the tender.³¹

Feedback from independent advocacy providers identified a number of areas for improvement in the current commissioning process. The contract/service specifications focus primarily on outputs rather than outcomes of advocacy. Providers considered that the contract monitoring arrangements do not fully reflect the complexities of the work of advocacy. The time spent on working with someone in a challenging situation where they need advocacy can, in some cases be substantial.

Independent advocacy providers would welcome a more outcome based model in reporting on advocacy. Effective advocacy services can lead to a range of quality outcomes, such as supporting human rights, improved wellbeing, social inclusion and reducing inequalities.

³⁰ http://www.dhsspsni.gov.uk/mipb_-_09-09.pdf

³¹ <http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf>

Advocates can also contribute to building effective links between organisations providing HSC services and groups representing the interests of particular client groups.

RQIA recommends that HSC organisations work with advocacy providers to develop outcome measures in service agreements for the provision of advocacy services.

Some advocacy providers considered that there were no safeguards to prevent an advocate being contracted in such situations who had no training in relation to the specific needs of that individual. HSC trusts advised that this would be an uncommon situation, and that they would seek to ensure that the principles for commissioning were followed.

Some independent advocacy providers raised concerns that they had experienced some difficulty in providing advocacy for a client if the service they are using is located in a different HSC trust area from where their place of residence is.

HSC trusts advised that arrangements for particular commissioned services vary. Some services are provided on a geographic basis for the HSC trust population. Others, including mental health services, will be commissioned to provide advocacy for anyone using the service provided by that HSC trust.

RQIA was provided with examples where advocates provide services across HSC trust boundaries, such as during resettlement programmes from long stay facilities.

RQIA recommends that HSC trusts review service agreements with advocacy providers to ensure clarity on the provision of services for clients across trust organisational boundaries.

Independent advocacy providers would welcome more clarity around structures and mechanisms that support the commissioning process. Independent advocacy providers highlighted that there is not always a clear source of guidance in relation to the contractual arrangements. They would welcome a dedicated point of contact with commissioners, who can provide advice and guidance, if required, where such arrangements are not already in place.

Recommendation 5	Priority 2
HSC organisations should work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning.	

Recommendation 6	Priority 2
HSC trusts should review service agreements with independent advocacy providers to ensure clarity as to the arrangements for provision of services for clients across trust organisational boundaries.	
Recommendation 7	Priority 1
HSC commissioning organisations should review their arrangements to ensure that there is a clear point of contact for service providers to provide advice and clarification in relation to service agreements.	

2.5 Monitoring adherence of Independent Advocacy Service Providers to the proposed Principles and Standards

RQIA found that the contractual agreements developed by the HSC Board and trusts contain statements that the independent advocacy service provider will work within an agreed set of principles and standards, as outlined within the DHSSPS policy guide.

The principles and standards outline what advocacy service providers need to do to ensure that they provide good quality advocacy. They apply to all models of advocacy and are intended to guide advocacy service providers.

RQIA found that the HSC Board and trusts have established processes to monitor the adherence of independent advocacy providers to the proposed principles and standards.

Monitoring and review of services delivered by independent advocacy providers is part of the agreed contract and service specification.

HSC commissioners have annual contract review meetings with each provider organisation. At these meetings documentation must be presented, including: ongoing monitoring forms; annual accounts; an annual report; and confirmation of insurance. Organisations are also asked to confirm that registration with Access NI is up to date for staff and volunteers. Relevant policies including: child protection, vulnerable adults, complaints and adverse incidents are expected to be up-to-date. Provider organisations can also be asked for minutes of relevant meetings, if required.

The contracts/service specifications set out robust reporting mechanisms and key performance indicators, which include quantitative and qualitative returns reported on a monthly, quarterly and annual basis. Management teams within the HSC trusts meet quarterly and annually with independent advocacy providers to ensure smooth delivery of services. The advocacy organisations are also required to produce end of year reports.

Service contracts set out requirements that the independent advocacy providers will ensure that advocates providing services have the required training and support to undertake the role. Training requirements include:

- Core induction training, which will cover the role of the advocate (including any legal obligations).
- The different models of advocacy and their relevance to equality and human rights laws and standards.
- Ongoing training requirements should be assessed by the advocacy provider to ensure, where possible, that adequate resources are identified and set aside for this purpose during the contractual period.

Training for advocates should be competency based and subject to ongoing assessment.

While systems are in place to ensure effective commissioning and monitoring of contracts for advocacy services, there is no requirement for organisations providing advocacy services, or for individual advocates, to be registered with any regulatory body.

RQIA was advised by some commissioning and providing organisations that they perceive the current lack of regulation as a significant gap in the provision of assurance of the quality of advocacy services. If not addressed this gap may widen in the context of the new mental capacity legislation with increased need for advocacy to be made available.

Recommendation 8	Priority 3
DHSSPS should review potential options for the introduction of regulation for advocacy services to determine if a regulatory framework should be established for organisations providing advocacy or for individual advocates	

2.6 Awareness of Advocacy Services, and the Importance of Independence, Among Health and Social Care Professionals and Service Users and Carers

The HSC Board and trusts advised RQIA of mechanisms in place to raise the awareness of advocacy services of HSC professionals and of service users and carers.

As part of the commissioning process and agreed contract service specification, the independent advocacy provider work within a range of key performance indicators (KPIs), which focus on activity delivered, for example:

- The delivery of two awareness sessions to HSC trust staff per year, with a minimum of 25 attendees at each session. This KPI is recorded and reported on a quarterly and annual basis.

The HSC Board and trusts also raise awareness through other processes including:

- HSC trusts publicise and promote advocacy services with relevant groups of staff and service users, outlining their responsibilities in promoting advocacy and providing information about services available in particular areas.
- HSC trusts involve advocates in staff inductions and invite them to present at staff meetings to share their experiences as independent advocates. Within children's services, HSC trusts provide a welcome pack, which includes information about independent advocacy services.
- Advocates have spoken at service forums, taken part in workshops for staff and participated in staff training.
- Advocates have also spoken at national and international conferences and shared their experiences of working within HSC trusts.
- HSC trusts have provided funding for training of peer advocates.

Independent advocacy providers highlighted that they raise awareness through a number of mechanisms including:

- Organising regional awareness raising events, conferences, and advocacy weeks.
- Training professionals in HSC trusts and students through working relationships with universities and professional bodies.
- Participating in a wide range of working groups, committees and alliances such as: ANNI; Helplines Network Northern Ireland; Mental Health and Learning Disability Alliance; a Royal College of Psychiatrists project; service user and carer improvement groups; HSC trust management groups; and the regional mental health services framework steering group.
- Placing leaflets and posters within the community at specific target points.
- Providing information online and through social media (Twitter and Facebook).
- Updating of HSC trust websites/intranet in partnership with their communications departments.

HSC Board informed RQIA that a lack of dedicated resource has prevented the development of a specific regional campaign to promote independent advocacy. Information has been shared about advocacy in regional service development and improvement activities where appropriate.

Some independent advocacy providers raised concerns that advocates do not always get invited to relevant meetings to support the person they advocate for. They also advised that some HSC professionals do not fully recognise the professional role of an independent advocate. They perceive that at times issues raised by advocates on behalf of their clients are regarded as complaints. They have found that there is still some resistance about working

with advocates in services, but this is lessening as the advocacy sector develops.

2.7 Implications of the New Mental Capacity Legislation on Future Provision of Advocacy Service in Northern Ireland

The development of a single legislative framework for the reform of mental health legislation, and for the introduction of mental capacity legislation in Northern Ireland was recommended by the Bamford Review in its report, published in 2007: A Comprehensive Legislative Framework.³²

The key recommendation in the 2007 report was: “There should be a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland”. The new framework would help reduce the stigma often associated with separate mental health legislation, and provide an opportunity to strengthen protections for people who lack capacity to make their own decisions. The vision was also of a framework that would apply to everyone in society, including those subject to the criminal justice system.

A new mental capacity legislation has now been drafted, and significant progress has been made in securing agreement to, and developing other aspects of the new framework.

The HSC Board, HSC trusts and advocacy providers acknowledged that the future direction of advocacy services will be greatly impacted by the new mental capacity legislation.

In 2014, during the consultation for the new Mental Capacity Legislation in Northern Ireland, approximately 45% of respondents received, commented on the inclusion of a statutory role for independent advocacy, that should be truly independent, commissioned regionally rather than directly by individual trust.

During the review, HSC organisations advised RQIA that there will be significant resource implications for implementation of the new capacity legislation. At present, it is not possible to fully assess the impact on provision of advocacy services, although this is likely to be substantial.

RQIA was advised that there may be additional complexity caused by the inclusion of 16 and 17 year olds in the proposed legislation. For a looked after child there may be tensions between different advocates, and, in some circumstances, between advocates and parents.

Legally, parents can make health and social welfare decisions on behalf of anyone under 18. There may be concerns if an advocate represents a child contrary to the wishes of a parent undermining parental responsibility. A

³² <http://www.dhsspsni.gov.uk/cl-framework>

guardian ad litem also has a role to ensure the best interests of children. In child care proceedings it will be vital to understand the roles and responsibilities of advocates appointed under the new capacity legislation.

2.8 Independent Advocacy Provider Involvement

The HSC Board informed the review team that stakeholder involvement for the development and improvement of existing independent advocacy services is facilitated through consultation with ANNI. However, as an umbrella group for independent advocacy providers, it would represent a conflict of interest to involve this forum directly in commissioning processes.

Where a requirement for new independent advocacy services is identified as part of a regional strategy, the stakeholders associated with that strategy are consulted and involved as necessary.

In relation to independent advocacy for children services, the HSC Board has endorsed the Ask First Standards (Northern Ireland Standards for Children and Young People's Participation in Public Decision Making, 2010),³³ which are a key tenet within children's procurement specifications.

RQIA found that HSC trusts have several mechanisms in place, through which both advocates and service users are involved in shaping how services are developed and delivered.

HSC trusts have established service user forums, support groups and networks for service users, carers and advocates. They are encouraged to bring forward the views of service users and carers, using the opportunity to highlight good practice and areas for improvement. The chair of these groups is supported as an equal member of senior management groups, and is part of all senior management decisions taking account of service user and carer views.

In addition to this, the recovery strategies in HSC trusts have a number of work streams to develop services that are recovery orientated and in the case of the recovery college, are co-produced and co-delivered with service users. Advocates are also part of these work streams.

Other services such as mental health services have in place steering groups to progress work in reshaping services to reflect the domains of the regional care pathway. Service users and advocates are integral to all the associated work streams of the groups and are helping to reshape services to be compliant with the pathway.

The Belfast Health and Social Care Trust was one of the first trusts to give voting rights to service users and carers on the trust's interview panels. Service users and carers have been at the heart of the design for two new

³³ http://www.ci-ni.org.uk/DatabaseDocs/nav_3175978_ask_first.pdf

mental health facilities (Old See House and the inpatient facility being built at Belfast City Hospital).

Under the contractual agreement, independent advocacy providers must have policies and procedures in place to support service users and carers to achieve their personal goals. The advocates will work under their code of practice and other policies which include: vulnerable adults; managing challenging behaviour; human rights and equality legislation

Chapter 3: Conclusions

During this review, RQIA found that the implementation of the DHSSPS policy guide and associated action plan, May 2012, has helped HSC commissioning organisations better understand and develop independent advocacy services in Northern Ireland.

The guide has given commissioners key principles to ensure they commission independent advocacy services in a consistent, fair and equitable way. The guide also provides commissioners and providers with standards to assure independent advocacy providers are delivering a safe, effective and compassionate service.

RQIA found that the HSC Board and trusts have effective commissioning arrangements in place. Commissioners adhere to relevant procurement legislation, and contracts reflect the regional principles and standards within the DHSSPS policy guide.

Where independent advocacy is the most appropriate service to meet an identified need or strategic objective, and funds are available, HSC organisations have clear arrangements and processes in place to commission that type of service.

The HSC Board has responsibility for commissioning regional advocacy services, mainly for children services, people with hearing impairment, and children with disabilities. The HSC Board also commissions advocacy in relation to resettlement of learning disability patients from hospital.

HSC trusts have responsibility for commissioning local advocacy services, primarily for family and child care, adult learning disability, and adult mental health. However, the review highlighted that existing provision is variable across other services such as hospital emergency departments, older people, cancer services, and for specific conditions such as dementia, Alzheimer's disease and autism.

RQIA found that current contracts focus primarily on outputs rather than outcomes. RQIA recommends further work to ensure a more outcome based model in reporting on advocacy, as effective advocacy can improve quality outcomes.

The development of a code of practice for advocates and other guidance by ANNI has been a positive development. However, further work is required to take this forward.

At present, there is no regulatory framework for advocacy services. RQIA recommends that options are considered to determine whether a framework should be established.

RQIA found that HSC organisations have successfully engaged with advocacy providers during the implementation of service changes.

RQIA found strong commitment among the commissioners and providers of independent advocacy services to take forward the role of advocacy in Northern Ireland. This will provide an important foundation to take forward the development of services to meet the challenges of providing independent advocacy to meet the requirements of the new mental capacity legislation.

Chapter 4: Summary of Recommendations

The eight recommendations have been prioritised in relation to the timescales in which they should be implemented.

- Priority 1 – to be completed within 6 months of publication of report
- Priority 2 – to be completed within 12 months of publication of report
- Priority 3 – to be completed within 18 months of publication of report

Recommendation 1	Priority 3
HSC trusts / Commissioners should carry out a needs assessment to determine future capacity requirements, and improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.	

Recommendation 2	Priority 3
HSC Board in partnership with relevant organisations should review and clarify arrangements for advocates to link with other sectors, including housing and education, when this is required in seeking to resolve cross-agency issues for their clients.	

Recommendation 3	Priority 2
HSC Board should work in partnership with HSC trusts and independent advocacy providers to consider other approaches such as newsletters or an annual event to share learning and experiences of advocacy services across organisations.	

Recommendation 4	Priority 3
The resource and training implications for advocacy services should be included in the assessment of requirements to take forward the implementation of the new mental capacity legislation.	

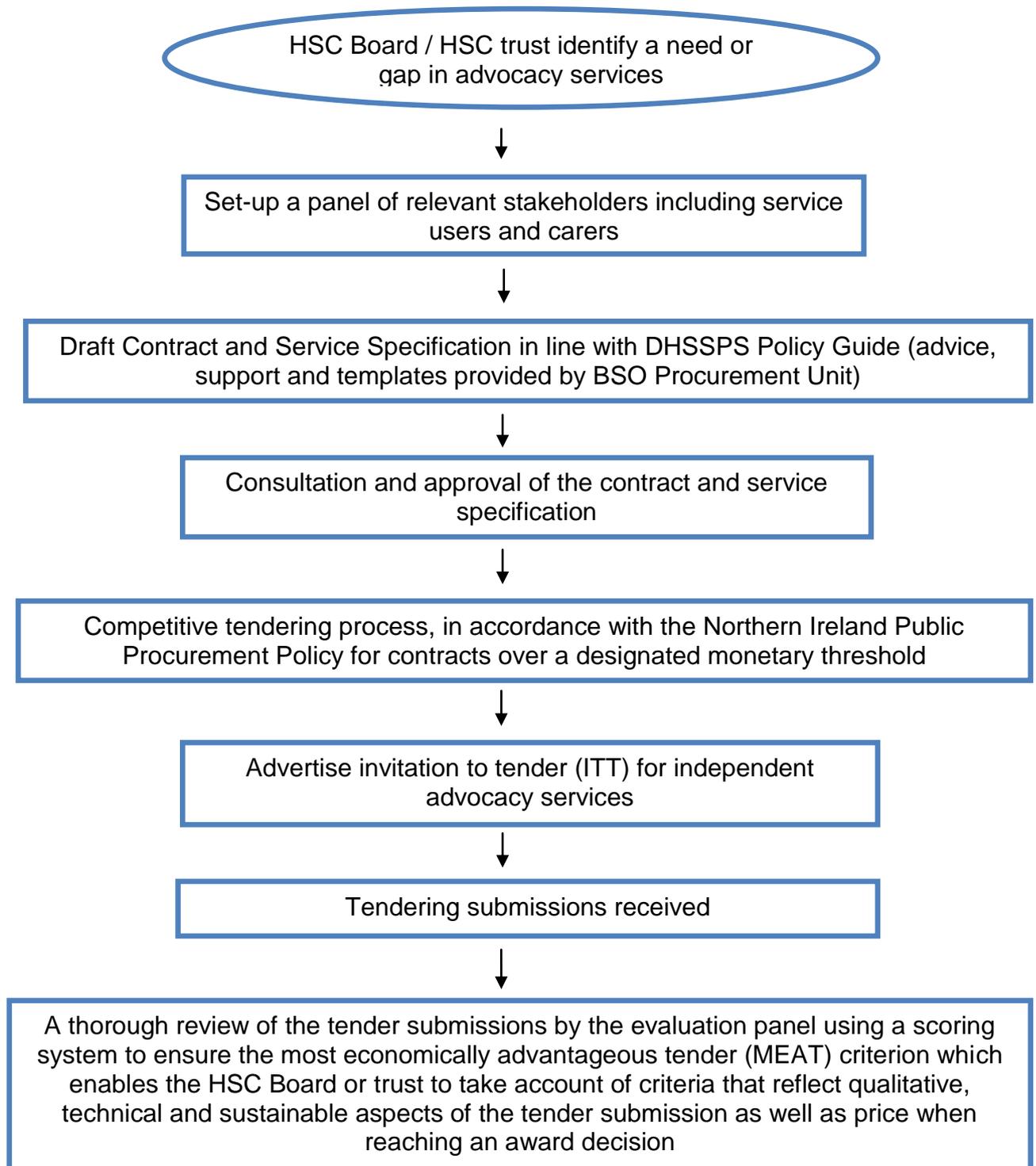
Recommendation 5	Priority 2
HSC organisations should work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning.	

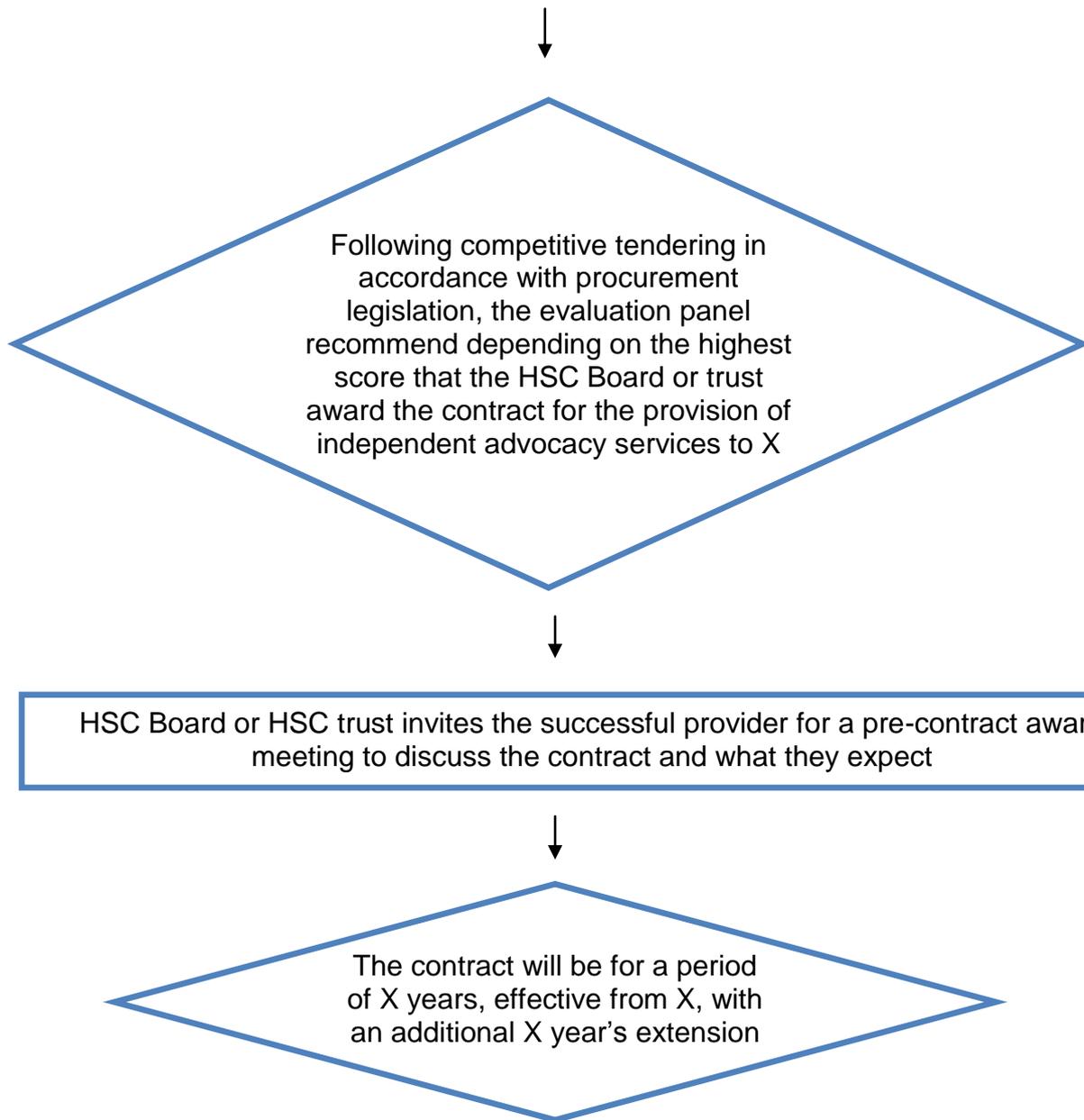
Recommendation 6	Priority 2
HSC trusts should review service agreements with independent advocacy providers to ensure clarity as to the arrangements for provision of services for clients across trust organisational boundaries.	

Recommendation 7	Priority 1
HSC commissioning organisations should review their arrangements to ensure that there is a clear point of contact for service providers to provide advice and clarification in relation to service agreements.	

Recommendation 8	Priority 3
DHSSPS should review potential options for the introduction of regulation for advocacy services to determine if a regulatory framework should be established for organisations providing advocacy or for individual advocates	

Appendix 1: Example Process Undertaken by the HSC Board and HSC Trusts when Commissioning Advocacy Services within Northern Ireland





Appendix 2: Abbreviations Used

AMH	Adult Mental Health
ALB	Arm Length Bodies
Belfast Trust	Belfast Health and Social Care Trust
BSO	Business Service Organisation
CAMHS	Child and adolescent mental health services
COPNI	Commissioner for Older People for Northern Ireland
CoPE	Centres of Procurement Expertise
DFP	Department of Finance and Personnel
EOLC	End of Life care
HSC Board	Health and Social Care Board
HSC	Health and Social Care
HSC trust	Health and Social Care trust
LCGs	Local Commissioning Groups
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NICCY	Northern Ireland Commissioner for Children and Young People
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
Northern Trust	Northern Health and Social Care Trust
OCN	Open College Network
PCC	Patient Client Council
PALs	Procurement and Logistics Service
PHA	Public Health Agency
SLA	Service Level Agreement
SIAA	Scottish Independent Advocacy Alliance
SCPG	Social Care Procurement Group
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
TILII Group	Telling It Like It Is
TOR	Terms of Reference
TYC	Transforming Your Care
Western Trust	Western Health and Social Care Trust
WTE	Whole Time Equivalent

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010

Review	Published
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013

Review	Published
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015



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