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SCIE GUIDE 31

Good practice guidance for the commissioning and monitoring of Independent Mental Capacity Advocate services

social care
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Written by David Thompson

This report is available online
www.scie.org.uk

Social Care Institute for Excellence
Goldings House
2 Hay's Lane
London SE1 2H
tel 020 7089 6840
fax 020 7089 6841
textphone 020 7089 6893
www.scie.org.uk

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Foreword by the Association of Directors of Adult Social Services

The Association of Directors of Adult Social Services (ADASS) is the national organisation in England and Northern Ireland representing directors of social care in local social services authorities. ADASS members are responsible for providing or commissioning, through the activities of their departments, the wellbeing, protection and care of hundreds of thousands of people, as well as for the promotion of their wellbeing and protection wherever it is needed. Close formal and informal links are maintained with the NHS and with central government in helping to shape and implement policy and social care legislation.

Within ADASS, the work on supporting the implementation of the Mental Capacity Act 2005, including the additional Deprivation of Liberty Safeguards, is located within our Mental Health Drugs and Alcohol Network. Greg Slay (West Sussex County Council) has been our lead officer in this work since 2005, recently and ably assisted by Lindsay Smith (Halton Council) and Richard Smith (Telford and Wrekin Council).

We are pleased to be partners with the Social Care Institute for Excellence, the Department of Health, the Office of the Public Guardian, and many other organisations in improving practitioner awareness of the Mental Capacity Act 2005.

The development of statutory advocacy for people who lack mental capacity to make specific decisions for themselves has been one of the many benefits of the Mental Capacity Act since its introduction in 2007. Local social services authorities, with their primary care trust partners, have been in the forefront of commending and celebrating the high-quality advocacy work provided in the first few years. From a standing start, the achievements have been a really impressive demonstration of the commitment of commissioners, service providers and practitioners to work together in the best interests of people who lack mental capacity.

We wholeheartedly endorse and recommend this comprehensive guidance to those responsible for commissioning and monitoring local IMCA services.

Richard Webb (Sheffield Council) and Jonathan Phillips (Calderdale Council)
Co-chairs, ADASS Mental Health Drugs and Alcohol Network

About this guide

This good practice guide has been produced by the Association of Directors of Adult Social Services and the Social Care Institute for Excellence (SCIE) to support the commissioning of the Independent Mental Capacity Advocate (IMCA) service. It was developed through consultation with a range of stakeholders including commissioners, local authority and health authority Mental Capacity Act leads and IMCA providers. The first version was published in October 2009 and updated in December 2010.

This guide is supported by SCIE's Mental Capacity Act advisory group. Membership of the advisory group includes representatives of the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS), Action for Advocacy (A4A), the Care Quality Commission (CQC) and the Office of the Public Guardian (OPG).

This good practice guide contains:

- issues to consider when reviewing IMCA contracts
- a revised example service specification
- suggestions for assessing quality
- an example engagement protocol
- suggested tender requirements.

For more information about this guide or SCIE's work supporting the IMCA service, please contact the SCIE MCA team at imca@scie.org.uk tel: 020 7089 6864.

Context

The commissioning of IMCA services by local authorities takes place in a very challenging financial climate. This makes it critical for local authorities to provide support to the most vulnerable. Many of these people will lack capacity to make important decisions and will be eligible for the IMCA service.

The October 2010 Spending Review settlement protected funds to support the implementation of the Mental Capacity Act, including funding of the IMCA service. The MCA funding has not been cut, and has an inflationary increase up to 2015 (see Local government and the spending review: annex)

The demand for the IMCA service continues to increase nationally year on year as the duties and powers to instruct IMCAs are better understood. Commissioning

arrangements need to pay careful attention to both the demand for and quality of the IMCA service.

The Department of Health has supported a number of initiatives to enhance the quality of the IMCA service. These include qualifications in independent advocacy provided by City and Guilds, and Quality Performance Mark for IMCA services provided by Action for Advocacy. The guide makes suggestions about how these can be incorporated into commissioning arrangements.

Reviewing IMCA contracts

This section identifies areas which commissioners will want to focus on when reviewing their IMCA commissioning arrangements.

Demand for the IMCA service

Local authorities are required to ensure that an IMCA service is available for those people who meet the criteria set down in the Mental Capacity Act (MCA) 2005 and the IMCA expansion of role regulations.

The initial estimates for the cost of the service by the DH made a number of assumptions for England including the following:

- There would be 10,000 IMCA instructions annually for accommodation decisions.
- There would be 6,000 IMCA instructions annually for serious medical treatment decisions.
- There would be 12,500 discretionary instructions for care reviews or safeguarding adults cases.
- IMCAs would spend an average of eight hours on most instructions. Additional time would be needed for more complex cases.

(Source: Explanatory memorandum to the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (expansion of role) regulations 2006.)

These assumptions give an average of about 55 IMCA instructions per year for an all age population of 100,000. For an adult (16+) population of 100,000 this would be 68. IMCA instructions.

There continues to be significant local variance regarding the level of instructions for the IMCA service which cannot all be attributed to differences in population profiles. For example, in some local authorities, eligible instructions in year three exceeded 40 per 100,000 population (all age) while in others it was below 5. Some IMCA providers report at times difficulties in meeting the demand for the IMCA service, however in other areas IMCA services are working under capacity.

Commissioners may want to calculate the rate of instructions for the size of their local population as part of the process of setting targets for the levels of activity for the IMCA service.

Use of discretionary powers

There is concern as to whether the discretionary powers to instruct an IMCA are being used effectively. Section 5.23 of the MCA Code of Practice says that all practical means should be used to enable and encourage the person to participate in best interests decisions. The instruction of an IMCA is a practical measure which should be considered in all cases where the discretionary power is available.

National data from the third year of the IMCA service shows that there were over six times as many accommodation instructions compared to those for care reviews. This raises two serious questions. The first is whether Section 7 guidance of undertaking a review within three months of a change in accommodation, and then at least annually, is being followed consistently for those people lacking capacity to make decisions about their accommodation who have no one appropriate to consult. The second is whether all possible support is being provided to people to participate when care reviews are arranged. For example, if an IMCA was instructed at a time when a person was moved to a new service, there would need to be clear justification as to why an IMCA was not instructed for all the subsequent care reviews.

The MCA Code of Practice (10.61) expects local authorities and National Health Service (NHS) bodies to establish a local policy for determining when an IMCA should be instructed for care reviews and safeguarding adults. Many local authorities have developed their guidance on IMCAs' involvement in safeguarding adults based on the ADASS/SCIE guidance.[1] Few, if any, have established similar guidance for the involvement of IMCAs in care reviews. Template policies for health trusts and local authorities are now available in the newly published ADASS/SCIE *Practice guidance on the IMCA role in accommodation decisions and care reviews* (2010).

Commissioners should identify whether these policies are available locally and if so whether they need to be reviewed.

Setting the budget

The DH has provided additional funding to local authorities and PCTs to meet their statutory obligations in relation to the MCA including the commissioning of IMCA services. For local authorities, these funds were confirmed for the year 2010/11 (see Local Authority Circular LAC (DH) (2010) 3). For 2011 to 2015 the funding for IMCA services for local authorities is included in the funds for Ongoing Personal Socials Services. This fund is protected with an inflationary increase (see Local government and the spending review: annex).

[1] ADASS & SCIE (2009) *Practice guidance on the involvement of Independent Mental Capacity Advocates (IMCAs) in safeguarding adults*.

In setting levels for future funding of IMCA services, commissioners will need to consider:

- the likely continued rise in demand for the IMCA service as knowledge of the MCA increases
- the additional demands on the IMCA service because of the DoLS' IMCA roles
- whether the discretionary powers to instruct IMCAs for care reviews and safeguarding adults decisions are being effectively used to ensure that individuals are given all possible support to have their views and wishes represented
- the infrastructure costs associated with supporting the delivery of a high-quality service that is always able to meet its statutory role in response to IMCA instructions
- risk strategies to meet a fluctuating and increasing demand
- potential legal costs incurred by the IMCA service in its role of supporting and representing individuals (see *Disputed case costs*, below).
- other advocacy work that is, or could be, undertaken by the IMCA provider, to support people lacking mental capacity
- the availability of other advocacy services locally which may impact on the need to use the discretionary powers in relation to care reviews and safeguarding adults.

Disputed case costs

Where there is a dispute which cannot be resolved locally, the MCA Code of Practice expects the local authority or health trust with responsibility for the decision to make an application to the Court of Protection. The MCA Code of Practice also identifies that IMCAs may themselves need to make an application to apply to the Court of Protection or for judicial review. Ensuring IMCA services have the resources to make applications is a key aspect of supporting the independence of the service.

IMCA services are not exempt from fees to access the Court. The current fees are £400 for an application and £500 for a hearing. IMCA services may incur other costs for initiating or being an interested party in legal action.

A potential inhibitor for the IMCA service to initiate legal action is the risk of the responsible body seeking to recover their costs from the IMCA service.

The original estimate for the cost of the IMCA service in England was £6.5 million. Of this it was expected that £0.5 million would be needed for disputed case costs. This could, for example, cover legal costs for the IMCA service to take cases to the Court of Protection. The expected disputed case costs were included in the provisional estimates for the cost of the IMCA service within the allocations to local authorities for MCA implementation – i.e. approximately 7.5 per cent of the suggested expenditure on IMCA service for 2007/08 was for disputed case costs.

Disputed case costs were not identified as a distinct budget area in the original example service specification. When reviewing commissioning arrangements local authorities may wish to consider the following:

- Identifying a proportion of the IMCA funding to be set aside for the service to pay for any legal costs directly associated with the IMCA role.
- Making a contractual agreement that the local authority will not seek to recover costs from the IMCA provider if legal action is taken involving the local authority.
- Seeking similar agreements from local health trusts.

Breakdown of budget

The example IMCA service specification (appendix 1) suggests breaking down the IMCA provider's budget into the following categories:

1. direct costs of providing IMCAs to respond to instructions – this to include case work, travel time and time spent in supervision. (The total hours of IMCAs' time should be recorded/split between direct advocacy and travel time.)
2. administration and overheads – *t*o include office costs, phone, IT and travel
3. management, training and supervision (the supervisor's time)
4. IMCA information service – the staffing costs of responding to enquiries about accessing the IMCA service
5. other activities to support the implementation of the MCA. – this could include staffing costs of any awareness-raising and training on the IMCA role, and participation in local strategic forums (for example, safeguarding adults boards and MCA implementation networks)
6. disputed legal costs **–** money used to pay any legal costs incurred by the IMCA service in relation to supporting and representing individuals.

In setting budget categories, it is useful to clarify:

- whether travel costs associated with IMCA case work are included as an overhead or direct advocacy cost
- whether travel time is included in the number of hours of advocacy provided
- whether the time the IMCA spends having their case work supervised is included in the number of hours of advocacy provided. Similarly, whether the time the supervisors spend supervising IMCA case work is included in the number of hours of advocacy provided
- how to allocate time spent responding to potential referrals before an IMCA is instructed. In some organisations this work is done by IMCAs, while in others it is done by referral coordinators. This means this cost could be allocated either as a direct advocacy cost or to administration.

The range of services provided

In reviewing contracts, commissioners will want to consider what services should be provided in addition to the statutory requirement of providing IMCAs in response to instructions.

IMCA providers continue to act as a significant source of informal support to a range of health and social care staff about the workings of the MCA including IMCA. A lot of time is spent by most IMCA services dealing with enquiries regarding people who may be eligible for the service. In moving the service forward, commissioners should ideally be looking to reduce the volume of time spent by IMCA service providers in supporting the health and social care workforce in its understanding of the role of the IMCA service.

Many IMCA providers take an active role in supporting the local implementation of the MCA in other ways. Examples include participation in local implementation networks and working with NHS trusts to ensure their policies and procedures identify when IMCA instruction should be considered.

Where levels of demand for the IMCA service are lower than expected, commissioners will want to consider how the IMCA service can support local authority and NHS staff to be aware of their statutory responsibilities regarding instruction.

The legislation and associated regulations set out when there is a duty or power to instruct an IMCA. Paragraph 4.12 of the Explanatory Memorandum to the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006), (Statutory Instrument 2006 no. 2883) states that the Expansion of

Role Regulations do not prevent an NHS body or local authority from instructing an IMCA in other circumstances.

Where the service has spare capacity, having taken and continuing to take all opportunities to promote the statutory IMCA service, commissioners may want to make arrangements and establish clear criteria for IMCAs to be available to represent and support other individuals lacking mental capacity where other best interests decisions are being made. In so doing it must always be made clear that the cases arising as a result of the local authorities' and NHS bodies' statutory duties and/or use of their discretionary powers must have the highest priority.

The example service specification indentifies five distinct functions of the IMCA service.

1. Providing IMCAs

Providing IMCAs to undertake the roles set out in the MCA and regulations when instructed by a person authorised to do so. This includes the additional IMCA roles introduced by the DoLS.

2. IMCA information service

This covers the work involved in responding to enquiries about access to the IMCA service. Typically this includes providing information about the eligibility criteria and process of instruction to people who may be aware of an individual who may require an IMCA. It is recommended that all work prior to the receipt of an instruction by an authorised person is considered as part of the IMCA information service.

3. Awareness-raising and training

This includes providing IMCA awareness-raising and training sessions to health and social care staff about the IMCA role. The extent to which the IMCA service undertakes this work may be determined by:

- The commissioning of and availability of other MCA awareness-raising and training opportunities.
- The ability of the IMCA service to respond directly and flexibly to need. This would include targeting specific teams or units where gaps in knowledge have been identified by an IMCA, for example arranging to attend a team meeting.
- The opportunity for the IMCA provider to vary the balance of work between responding to IMCA instructions and awareness-raising and training.

4. Supporting the local integration of the MCA into policy and practice

Good practice is for the IMCA service to be a key partner in supporting the local integration of the MCA into practice. This includes contributing to any local implementation networks and safeguarding adult boards. It may also involve identifying and supporting local policy and practice issues. Through their work, IMCAs are in a unique position to identify gaps in knowledge of the MCA.

5. Providing additional advocacy services

One way to commission against a backdrop of fluctuating and expected increasing IMCA instructions is to permit the IMCA service to provide services other than those where the local authority or NHS body is required to, or may provide by statute where, as above, there is capacity to do so.

Meeting the varying level of IMCA instructions

IMCA providers have very limited control over both the number of, and timescales for, individual IMCA instructions. This can make managing the flow of work challenging, even without unpredicted staff absences.

Commissioning should focus on how the IMCA provider does, or would, efficiently manage a varying workload. This is particularly important in local authorities with relatively small populations.

The original guidance suggested that a number of part-time advocates (who may combine the specialist IMCA role with other forms of advocacy) would provide a more flexible service than, for example, one full-time advocate. This has proved to be effective in many local services.

In many local authorities, efficient commissioning of the IMCA service will involve one or both of the following:

- The IMCA service being commissioned by more than one local authority in a geographic area. This gives IMCAs the opportunity to work flexibly across a number of areas to meet varying demand for the service.
- Commissioning the IMCA service as part of a wider local advocacy service. Advocates would be able to balance a case load of IMCA and non IMCA work.

Supporting the independence of the IMCA service

The draft service specification said that IMCA providers should be independent of the local authority, with their own constitution, code of practice and complaints procedure. It also said that the IMCAs will be managed by, and primarily accountable to, the advocacy organisation that recruits and employs them, thereby maintaining their independence from the local service providers.

There are significant risks to the independence of IMCA providers because they are commissioned by local authorities who are responsible for many of the decisions IMCAs are instructed for. For example, the IMCA provider may need to take formal action against the local authority in relation to an accommodation decision.

Good practice is for commissioners to identify the means of safeguarding independence in funding agreements and contracts. This would include the following:

- Having a clear system for resolving disputes which could be included in an engagement protocol. For example, this could allow the IMCA provider to raise issues in relation to IMCA instructions at a senior level within the local authority.

- The commissioning authority not being involved in any matters of staff deployment or discipline. This would include not trying to determine whether a particular IMCA does or does not support and represent a specific individual.

- Identifying how the IMCA service's legal costs would be met if it makes an application to apply to the Court of Protection or for judicial review (see *Disputed case costs* above)

Steering groups

The original example service specification suggested that IMCA steering groups be set up and meet quarterly. In addition to the commissioner and IMCA provider, membership was to include representatives of health and social services.

Consistent feedback in developing this guidance has been that steering groups have been a critical factor in the effective delivery of the IMCA service. Where steering groups have maintained the participation of senior managers in health and social care services, they have provided an effective escalation and mediation point for issues arising with the service. This forum can, for example, avoid the need for some applications to the Court of Protection. Steering groups can also be robust defenders of the IMCA provider's independence.

The steering group can also function to address any systemic issues identified in the access to, or the function of, the IMCA service. The operation of the steering group is usefully embedded in engagement protocols.

Where the Mental Capacity Act is being successfully integrated into health and social care practice, the need for a specific IMCA steering group may be reviewed. In some areas the functions of the IMCA steering group have been incorporated into wider MCA implementation networks. In others they have been transferred into local safeguarding boards.

Which local authority is responsible for commissioning?

The MCA Code of Practice says the IMCA service to be instructed is the one which 'works wherever the person is at the time that the person needs support and representation' (10.12).

There is a strong consensus for which local authority is responsible for commissioning the IMCA service for the different IMCA roles. This is set out below and included in the example service specification.

- *Accommodation decisions and 39A IMCA role:* where the person is staying before a possible move, for example in hospital awaiting discharge.
- *SMT decisions:* where the person is staying rather than where the medical practioners who need to make the decision are based (e.g. if the person has an outpatient appointment with a consultant who has made the instruction in a different local authority it would be the IMCA service where they live).
- *Safeguarding adult cases:* where the person is staying. In the majority of cases this will be the local authority which is responsible for coordinating the safeguarding adults process. In exceptional circumstances the person may be staying in a different local authority to where the abuse is alleged to have occurred.
- *Care reviews, 39C IMCA roles:* where the person is staying.
- *39D IMCA role:* where the person is staying. This includes if the IMCA is instructed to support a relevant person's representative who lives in a different area. This is because the IMCA is still required to meet the person where practical and appropriate. The IMCA's support to the person's representative may be provided over the phone or in person when they have the required contact with the person they are representing.

Where the person is staying may change to a different local authority after the instruction of an IMCA and before decisions are made. For example:

- A person who has an IMCA instructed for an SMT decision may be admitted into hospital before final decisions have been made about their treatment.
- A person who has an IMCA instructed for safeguarding adult decision may be moved temporarily during the investigation process.
- A person who has an IMCA instructed for an accommodation decision may need to move into temporary accommodation.

In many such cases it would be desirable for the same IMCA service to continue to work with the person. In others, particularly where the person has moved a significant distance away, where they are unlikely to return to the original local authority, or where the IMCA has limited contact with the person before the move, it may be appropriate for another IMCA service to be instructed.

There is a positive picture of different IMCA services working flexibly in such situations and so there is little need to specify what should happen in such cases in the service specification.

The commissioning responsibilities set out above have avoided the need to cross charge local authorities or health trusts. It is unlikely that there would be any financial saving to local authorities were they to attempt to charge for 'out-of-area' instructions. The administrative costs of any 'recharging' may instead increase the real costs for the IMCA service.

Availability of service

The draft service specification suggested the IMCA service should be available during office hours, every weekday, except public holidays. It also suggested that IMCAs would be available outside these times by arrangement to meet the needs of the service. This is the predominant model which has been adopted and has been widely considered to be effective.

The new section 39A IMCA role related to the DoLS is putting additional demands on service availability, particularly the potential need to work outside office hours. The 39A IMCA may be instructed in relation to an assessment which needs to be completed within seven calendar days (either in relation to a potential unauthorised deprivation of liberty or a request for a standard authorisation where an urgent authorisation is in place).

There is some early evidence that 39A IMCAs are not always being instructed as soon as possible in this seven-day period by supervisory bodies. It is preferable for this to be addressed with supervisory bodies rather than to use it as a rationale to extend the availability of the IMCA service to include weekends and public holidays.

The process of instruction and withdrawal of instruction

The MCA and associated regulations set out that instructions can be made by local authority or health staff. The IMCA service is required to verify that the instruction was made by an authorised person. In checking whether the instruction was made by an authorised person the IMCA service is necessarily required to check that the reason for the instruction falls within the scope of the MCA. For example, if support is requested by a social worker to help a person decide what they do during the day, the requirement of an instruction by an authorised person has not been met.

It is suggested that the term *authorised instruction* is used to denote an IMCA instruction which falls within the scope of the MCA and has been made by an authorised person.

Once an authorised instruction has been made, different practice has emerged for situations where the IMCA service believes that the person is not eligible for the service – for example if they understand that there is someone appropriate to consult. This varies between the IMCA service *not accepting* the instruction, to the IMCA service raising the matter with the instructor and giving them the opportunity to consider withdrawing the instruction. To avoid any confusion it is suggested that it is written into the service specification that once instructed by an authorised person, the IMCA service must be provided unless the instruction is withdrawn by the authorised person.

Situations have also arisen where an authorised instruction is withdrawn but an IMCA service believes the person is both eligible for the service and would benefit from it. An example being the instructor reviewing their view as to whether the person has no one appropriate to consult.

To protect the independence of the IMCA role, it is suggested that the service specification allows for the possibility of the IMCA service to continue working with individuals where an authorised instruction has been withdrawn but only if there are concerns about an aspect of the decision-making process. For example, if instruction is withdrawn because the person has been assessed as having capacity to make the decision the IMCA was originally instructed for, an IMCA might continue working with the person if they were challenging that assessment of capacity. In such situations the IMCA would not retain their statutory rights to, for example, access relevant records or meet the person in private.

Good practice is for the IMCA to provide written confirmation to the instructor when they have concluded their work with an individual.

Different practice has emerged regarding the place of capacity assessments in the instruction process. There is a requirement in all IMCA instructions (apart from the 39A IMCA role) that the person has been assessed as lacking capacity for the matter in question.

Typically, IMCA providers remind potential instructors of the requirement for the person's capacity to make the decision in question to have been assessed, however there is a significant divergence in practice once instruction has been made (which may or may not have been established through local protocols with responsible bodies). The two main responses can be summarised as follows:

- The IMCA provider has been instructed to work with the individual and proceeds to do so. If at any time they have concerns that the person has capacity to make the decision, they may raise this with the instructor, including seeking evidence of the original capacity assessment. If the person is assessed as having capacity (or if a capacity assessment has not been undertaken), the IMCA may suggest that the instruction is withdrawn.
- The IMCA provider requires written evidence of a mental capacity assessment before proceeding to work with the individual.

The first response limits the administrative requirements of making an instruction. This can make it easier for people to access the service and also minimise the costs associated with the process of instruction for local authorities and NHS bodies. This is the approach supported in the example service specification. The second response goes beyond the statutory requirement of verifying the instruction was received from an authorised person.

Action for Advocacy has produced a good practice guide on IMCA instruction.[2]

IMCA reports

For all authorised instructions there is a statutory requirement for IMCAs to prepare reports for the person who instructed them. It is also good practice for the IMCA service to confirm in writing when they have stopped working with an individual. The example service specification reinforces the requirement for IMCA reports to be provided, including when instructions are withdrawn or if the individual dies (in the latter situation this is likely to be a short acknowledgement that the IMCA role has ended).

The section on monitoring identifies that an analysis of a sample of IMCA reports is a potential way to monitor the quality of the IMCA service. Good practice guidance in report writing is available from Action for Advocacy.[3]

The training and qualification of IMCAs

The MCA 2005 and IMCAs (General) Regulations 2006 give local authorities the power to set what training and qualification is required of IMCAs. This is subject to requirements set out in the MCA Code of Practice that IMCAs need to have completed the IMCA training. Initially, this was a four-day course run by Action for Advocacy. The majority of people currently working as an IMCA will have attended this training. This has now been superseded by unit 305 of the advocacy qualification (see below) which is similarly offered by some providers as a four-day course but is assessed.

In advance of the implementation of the DoLS, the DH commissioned a two-day training course which focused specifically on the new IMCA roles. This was again delivered by Action for Advocacy. The DH expected that any IMCAs undertaking such work would have completed this course and have had at least three months' experience as an IMCA, and/or worked on three IMCA cases. More than half of all previously trained

[2] Action for Advocacy (2010). IMCA instruction: best practice guidance. http://www.scie.org.uk/publications/imca/files/imcainstructionguide.pdf
[3] Action for Advocacy (2010). IMCA report writing: best practice guidance. http://www.scie.org.uk/publications/imca/files/imcareportwritingguidance.pdf

IMCAs/IMCA managers attended this training. This has been superseded by unit 310 of the advocacy qualification (see below).

Since March 2009, national qualifications in independent advocacy have been available which were supported by the DH. These are City & Guilds qualifications (City & Guilds course handbook), based on four core units and six optional units. Two of the optional units specifically focus on IMCA:

- unit 305, 'Providing Independent Mental Capacity Advocacy' ('the IMCA unit')
- unit 310, 'Providing Independent Mental Capacity Advocacy – Deprivation of Liberty Safeguards' ('the DoLS unit').

To achieve the level three Certificate in Independent Advocacy (Independent Mental Capacity Advocacy) candidates are required to complete the four core units and the IMCA unit 305.

To achieve the level three diploma in Independent Mental Capacity Advocacy (Deprivation of Liberty Safeguards), candidates need to have the IMCA certificate and in addition complete the DoLS unit 310.

The qualifications are available from a range of providers. (See SCIE's IMCA pages for a complete list). Some providers offered conversion courses for units 305 and 310 for those IMCAs who attended the original training courses.

Now the advocacy qualifications are available the expectation is that all IMCAs will complete unit 305. Further, if IMCAs are to undertake any of the IMCA roles associated with the DoLS they should also complete unit 310.

The DH made available funds for IMCA providers in April 2009 to support practising IMCAs obtain the qualifications. This was £1,000 per IMCA.

- The cost for a single unit is about £550.
- Where an IMCA has already undertaken the training the cost for the conversion assessment for unit 305 or 310 is about £350.
- The cost of the full certificate is in the order of £1,500.
- The cost of the full diploma is in the order of £2,000.

The qualifications are competency-based. To successfully complete each unit, candidates are required to provide evidence of real work practice. This means that it is not possible for new IMCAs to complete the assessment part of unit 305 before starting working in the IMCA role. Similarly, local levels of DoLS instructions will impact on the ability of IMCAs to complete unit 310.

The DH made the following recommendation with regard to the training and qualification of Independent Mental Health Advocates (IMHAs).

> *IMHAs should be expected to have successfully completed the IMHA module by the end of their first year of practice (making necessary adjustments for any maternity leave, long term sickness or other similar absences).*
> *(Standards: appropriate experience and training Gateway reference: 10593, DH)*

This refers to unit 306 of the qualification in independent advocacy. A similar expectation could be applied for the completion of units 305 and 310 for IMCAs.

Commissioners will want to ensure that the service specification supports the following:

- All IMCAs successfully complete unit 305 and, if undertaking DoLS roles, unit 310, within appropriate timescales.
- New IMCAs do not practise until they have received training for unit 305.
- IMCAs do not undertake DoLS roles until they have received training for unit 310.
- Case work which is being undertaken by IMCAs who are yet to complete the assessment of unit 305 or 310 are being supervised by an IMCA who has completed the relevant unit(s). The name of the supervisor could be included on IMCA reports.

Commissioners should be aware that new IMCAs may need to wait a number of months before being able to access training for units 305 and 310.

Commissioners will want to take a view as to whether IMCAs are required to work towards completing the full certificate or diploma in independent advocacy. Consideration needs to be given to the resources required to support this target.

Continuing professional development

In addition to completing units 305 and 310, expectations should be placed on IMCA providers to ensure all IMCAs access further relevant training. This may cover:

- good practice in safeguarding adults (SCIE provides training to IMCAs in this area)
- working with the different client groups who may access the IMCA service (the Dementia Advice Network can support IMCAs working with people who have dementia)
- report writing (Action for Advocacy provides training in this area)
- participation in regional forums for IMCAs.

Monitoring information

The draft service specification (appendix 1) sets out a range of suggested information that IMCA services should provide for monitoring purposes. This includes:

- number of eligible and ineligible referrals
- types of referral, i.e. accommodation, serious medical treatment (SMT), etc
- figures relating to age, ethnicity and gender
- hours spent on case work
- complaints and compliments
- staff turnover
- training and supervision of staff.

This information is expected to be provided quarterly. Some concern has been expressed that some IMCA providers are required to collect additional data which is time-consuming to collate but provides little information about the functioning or quality of the service.

DH IMCA database

Since April 2007 the DH has expected all IMCA services to log individual cases on a national database. In addition to the case data above, it asks specifically about:

- nature of mental impairment
- why referrals were deemed ineligible
- second medical opinions
- whether a formal challenge was undertaken
- where the person was at the time of referral
- nature of SMT decisions
- whether IMCA reports were submitted and the reason if not.

The current questions asked on the DH IMCA database are included in Appendix 2.

The database allows analysis of the IMCA service nationally. Most IMCA providers in addition maintain their own databases to support the recording of the IMCAs work in relation to individual instructions.

An annual analysis of the national data is available from the IMCA page on the DH website.

IMCA providers can produce reports from the DH website regarding the services they provide. Local authorities are able to access information about the IMCA services they commission.

Commissioners will want to include a requirement for the IMCA provider to maintain the DH's IMCA database in the services specification.

There needs to be extreme caution about trying to make comparisons of quality between different IMCA providers from the DH IMCA database. This is because individual IMCAs and providers may answer some questions quite differently. For example, in response to the question whether the IMCA challenged the outcome, some IMCAs will only mark 'yes' if a formal challenge was initiated (e.g. a formal complaint or legal action) while others will mark 'yes' if the IMCA informally raised issues which may have led to a different outcome for the person. Similarly, in response to whether the IMCA was satisfied that their involvement provided a safeguard for the client, some IMCAs are only marking 'yes' if they believed they positively affected the outcome for the person, while others are marking 'yes' if, regardless of the impact of the IMCA, the outcome for the person was satisfactory.

Assessing the quality of the IMCA service

Commissioners will want to evidence the quality of IMCA services: both when a provider is commissioned and when it is providing the local service.

Particular challenges in assessing the quality of IMCA services include:

- The difficulty of obtaining direct feedback from service users due to their lack of capacity to make certain decisions.
- Often the IMCA role of providing a safeguard will be well satisfied without the IMCA making a significant impact on the outcome for the individual.
- The number of formal challenges raised by the IMCA service is only indirectly related to quality. For example, instigating formal challenges could be seen as evidence of an IMCA service's commitment to representing individuals but also as a lack of skills to successfully resolve issues informally.

Indicators of quality can be grouped into two areas:

1. Quality of the service provider:

- training, qualification and supervision of IMCAs
- the organisation having achieved external quality marks.

2. Quality of the IMCA service provided:

- feedback from people making instructions
- IMCA reports
- Views of people who use services
- the difference the IMCA's involvement has made.

More information about these is provided below.

External quality marks

IMCA providers working towards or having achieved external quality marks is also considered widely to be a reliable indicator of the quality of the service. The potential quality marks include the Community Legal Services Quality Mark, Investors in People, PQASSO and ISO 9000.

A specific advocacy quality mark was launched by A4A in 2008. This was developed in response to the need for advocacy schemes to demonstrate their quality and the limited 'fit' of existing quality marks. Information about the Advocacy Quality Performance Mark can be found on A4A's website. The quality mark now has an option for an IMCA specific review. The quality indicators used are freely available. This allows commissioners to use them directly to support the assessment of the quality of local advocacy schemes.

Feedback from people making instructions

Probably the most commonly used quality indicator is feedback from those people who instructed the IMCA service. This is widely considered to be a valid indicator of quality. Usually this takes the form of a questionnaire being sent to these people at the end of an IMCA's work with an individual. Rates of return of these questionnaires have been a difficulty in many areas. In a small number of local authorities, commissioners have directly contacted a proportion of these people for feedback about the IMCA service. Typical questions asked include the following:

- What is the overall satisfaction rating of the IMCA service?
- Did the IMCA respond promptly to the instruction?
- Did having an IMCA make a difference to the person's views being heard?
- Did the IMCA put the service user at the heart of the decision-making process?
- Was the final report of a good standard?
- Did the report make a difference in the decision-making process?

There is a risk of a conflict of interests in relation to the decision makers' view of the IMCA service and the outcome for the service user. For example, while a decision-maker may rate an IMCA service positively for not formally challenging their decision, this does not necessarily mean that the IMCA service has been of a high quality.

Further suggestions are given in Appendix 4.

Using IMCA reports to identify quality

IMCA reports are a useful focus for identifying the quality of IMCA services. Good IMCA reports will, for example, demonstrate the following concerning the IMCA's work:

- Understanding of both the MCA and their role.
- The work they have done to identify, support and represent the person's views and wishes.
- The report being provided at an appropriate time to support decision-making.

A focus on IMCA reports is consistent with the common use of such reports to demonstrate that IMCAs meet the learning outcomes required for the IMCA units of the national advocacy qualification.

Commissioners may want to consider ways of sampling and quality-checking IMCA reports which do not compromise the confidentiality of individuals. There is a potential role for steering group members here. Action for Advocacy's report writing: best practice guidance is a useful tool.

Sampling could cover the following instructions:

- Specific types of IMCA instructions, for example SMT, 39A or accommodation decisions where a move from a person's own home is being considered (see below).
- Where the IMCA has a significant impact on the outcome.
- Where formal action was initiated by either the IMCA provider or responsible body.
- Where the outcome went against the client's views (see below).

Further suggestions are given in Appendix 5.

Using service user views as a focus for quality

As identified above, there are particular challenges to collecting feedback from the service users on the quality of the IMCA service they received. It can be more useful to focus on any views they have about the outcome of the process for which the IMCA was instructed to support and represent them.

The service user's views (including those expressed at an earlier time) can be categorised in the following way in relation to the outcome of the process:

- the outcome reflected the service user's views
- the outcome went against the service user's views
- service user had mixed feelings about the outcome
- not possible to establish the service user's views.

Nationally, only in about 8 per cent of cases does the outcome go against the service user's expressed wishes. The outcome in these situations may of course be in the person's best interests.

Focusing on these specific cases is a potential way to include the views of service users in the monitoring of IMCA services. This is because it could be assumed that, were these people to have capacity, they would be dissatisfied with the IMCA service's representation of their views.

Commissioners may want to consider asking IMCA providers to identify instructions where the outcome went against the views of the individual and to provide information about the following:

- what they did to support the person and represent their views
- what they did to ensure alternatives were considered which were closer in line with the person's views
- why they did not proceed with formally challenging the decision.

In some cases it may be possible to gain further feedback directly from the individual.

Another potential focus for quality related to client views is IMCA instructions for accommodation decisions where the person was living in their own home. The national figures identify that only a very small proportion of people in this situation had the opportunity to continue living in their home, with the vast majority moving to a residential care home. Even if the person was unable to express a view it could be the case that they would have wanted all possible support to remain in their own home. The IMCAs' work could be examined in these cases to see if they ensured that alternatives to moving to a care home were adequately explored. This would include making full use of the opportunities of personalisation.

Further suggestions are given in Appendix 6.

Measuring the difference the IMCA service has made

There is some concern that monitoring information is too much focused on the process of IMCA involvement rather than its outcomes. One development is to look at the difference IMCAs have made to:

- how the person was involved in the decision-making process
- the outcome of the decision
- other aspects of the person's care and support
- the practice of health and social care staff.

Looking at the difference the IMCA service makes, challenges IMCAs to consider how they can best use their time to support improvements for individuals. One way this can be done is by providing a summary of a person's needs and wishes to a care home which someone has moved into. This could help the person receive a personalised service in the care home (see ADASS/SCIE IMCA guidance for accommodation decisions and care reviews). Looking at the difference may also mean IMCAs limiting their involvement in those cases where they may have little or no impact.

The Norah Fry Research Centre is currently undertaking research into the difference IMCAs make in this area. This may help provide bench marks for the future monitoring of IMCA services and a reliable way to compare quality between different providers.

Appendix 7 set out the areas examined by the Norah Fry Research Centre. They are included as headings for monitoring data in the example service specification (Appendix 1).

Appendix 1: Example IMCA service specification

Introduction

The service specification is a revision of the example produced by the DH in 2006. It reflects the experience of commissioning and providing the IMCA service and the extension of the IMCA role because of the DoLS. The rationale for the suggested changes is discussed in the *Issues to consider when reviewing contracts* section above.

Sections marked in [square brackets] may vary according to local factors.

Timing

The service will commence from [1 April 2011] and will be of [five] years duration. Subject to satisfactory performance it may be extended by agreement of both parties for a further period of [two] years.

Purpose of the service

The purpose is to provide an IMCA service to people covered by the MCA 2005. There are five distinct parts of this service [commissioners will need to take a view as to whether the last three of these are included in the contract].

1. Providing IMCAs

- When instructed, provide IMCAs to undertake the roles set out in the MCA and associated regulations.
- The IMCA service must be available to all service users who may be eligible. This includes people with learning disabilities, dementia, mental health needs and acquired brain injury.
- Instruction will be made by local authority or health staff as authorised in the MCA [subject to any local policy]. Instructions must be made in writing. The IMCA service will verify that the instruction was made by an authorised person and that the appropriate IMCA service has been instructed. Once these have been established the IMCA service will be provided.
- If the IMCA service has concerns about whether an individual is eligible for the IMCA service for any other reason (e.g. the person having someone appropriate to consult) these may be raised at any time with the person making the instruction. A decision to withdraw an instruction sits with the instructor and not the IMCA service.

- Where instruction is withdrawn, the IMCA will cease representing the individual unless they have concerns about an aspect of the decision-making process. For example, if instruction is withdrawn because the person has been assessed as having capacity to make the decision the IMCA was originally instructed for, an IMCA might continue working with the person if they are challenging that assessment of capacity.
- If instruction is withdrawn, the IMCA's statutory rights of, for example, access to relevant records and meeting the person in private no longer apply.
- IMCA written reports will be provided to the instructor for all instructions made. This will include instructions where the instruction was withdrawn or the person died.
- The IMCA will provide written confirmation to the instructor when they have ended their work with all individuals.

2. Information service

- To provide an information service about the IMCA role and the requirements of IMCA instruction for people contacting the service regarding service users who may be eligible for an IMCA. Contact may be made by email, phone or post.
- Information about the IMCA service will be available on a website maintained by the IMCA provider.

3. Awareness and training

- To provide IMCA awareness and training sessions to the NHS and social care staff who may come into contact with people who are eligible for the IMCA service.
- Decisions about where this work is targeted will be made in consultation with the local authority and health trusts.

4. Supporting the local integration of the MCA into policy and practice

- The IMCA service will be a key partner in supporting the local integration of the MCA into practice. This would include contributing to [the local implementation network, the safeguarding board] and both identifying and supporting local policy and practice issues.

5. Providing additional advocacy services

- Where there is capacity, additional individual advocacy will be provided.

- This service should be available in the following circumstances [ ].

IMCA instructions covered in this service specification

The IMCA service will provide a service to all individuals staying at the time of instruction within the local authority, regardless of the person's ordinary residence/funding authority. Staying includes temporarily living within the local authority and being an inpatient of a hospital in the area.

Where the person is staying may change to a different local authority after the instruction of an IMCA and before decisions are made. For example:

- A person who has an IMCA instructed for an SMT decision may be admitted into hospital before final decisions have been made about their treatment.
- A person who has an IMCA instructed for a safeguarding adults decision may be moved temporarily during the investigation process.
- A person who has an IMCA instructed for an accommodation decision may need to move into temporary accommodation.

Where this occurs the originally instructed IMCA service should continue to support and represent the person unless the IMCA service where the person is newly resident is instructed. The decision to involve a different IMCA service sits with the instructor, and should be made after discussion with the original IMCA service. In many cases it would be desirable for the original IMCA service to continue to work with the person. In others, particularly where the person has moved a significant distance away, where it is unlikely they will return to the area of the original local authority, or where the IMCA has had limited contact with the person before the move, it will be more appropriate for another IMCA service to be instructed.

Availability of service

- The IMCA service should be available during office hours [9.30–5.00 Monday–Thursday, 9.30–4.30 Friday], except public holidays.
- IMCAs will be available during these times, and by arrangement outside of these times to meet the needs of the service.
- An answer-machine service should be available outside these hours to facilitate contact with the service.
- Arrangements need to be in place to ensure continuity of service, for example, during annual leave and staff sickness.

Service principles

The IMCA service must provide high-quality non-instructed advocacy for people with a variety of communication needs.

The service provided must be appropriate to people's needs, including their disability, race, culture, religion, sexuality, age and gender. The service must also recognise that individuals' needs can change over time and respond accordingly.

The IMCA service must work in partnership with other agencies: statutory, independent and voluntary. This will include hospital discharge staff, doctors, nurses, social workers, care managers and managers of care homes. It must assist staff and service managers who are likely to refer their patients, and service users, to understand the role of the IMCA and know how and when to access the service.

The service will meet all statutory standards that might apply to it at any given time and will be able to evidence this, including in written policy statements. This includes standards relating to independence, Criminal Records Bureau checks and training.

The IMCA provider will:

- Be independent of the local authorities and health services with its own constitution, and its complaints procedure.
- Recruit, manage and supervise IMCAs.
- Provide monitoring reports for the local authority [quarterly].
- Input data for all cases into the DH IMCA database.
- Meet periodically [quarterly] with commissioners and local authority/NHS representatives as part of the IMCA steering to i) report and discuss general progress; ii) feed back issues on the provision of IMCA locally; iii) discuss any service issues.
- Provide information to the local authority about any complaints received about the IMCA service.
- Comply with data protection requirements.

Requirements for who can undertake the IMCA roles

Before undertaking any IMCA roles the service provider must ensure that each IMCA:

- Is a person of integrity and good character. This should be evidenced by two written references, including, where applicable, a reference relating to the IMCA's last period of employment, which involved work with children or vulnerable adults, of not less than three months' duration. Where a person has previously worked in a position which involved contact with children or vulnerable adults, written verification should be obtained of the reason why he/she ceased to work in that position unless it is not reasonably practicable to obtain such verification.

- Has an enhanced criminal record certificate issued pursuant to section 113B of the Police Act 1997. This should be sought a minimum of every [three] years for existing IMCAs.
- Has attended training to undertake the role. This is either the four-day IMCA training originally provided by Action for Advocacy or all of the training/taught components of unit 305 of the national advocacy qualification available through City & Guilds.
- Has successfully completed the assessment of unit 305 within [one year] of working as an IMCA or by [1 April 2011] – whichever is the latest.

The IMCA provider may seek an extension for completing the qualification for an individual IMCA because of maternity leave, long-term sickness or other similar absences. This needs to be discussed with and agreed with the commissioning authority before the IMCA continues to provide the service after the deadlines above.

IMCA DoLS roles

Before undertaking any of the IMCA DoLS roles (39A, 39C, 39D) the following additional requirement must be met for each IMCA:

- The IMCA must have acted as an IMCA for at least three months or worked on at least three cases.
- The IMCA has attended training to undertake this role. This is either the two-day IMCA DoLS training originally provided by A4A or all of the training/taught components of unit 310 of the national advocacy qualification.
- The IMCA has successfully completed the assessment of unit 310 within [one year] of undertaking the DoLS IMCA roles or by [1st April 2011] – whichever is the latest.

The IMCA provider may seek an extension for completing the qualification for an individual IMCA because of maternity leave, long-term sickness or other similar absences. An extension may also be requested here if the IMCA has not had an adequate case load to demonstrate their competencies for the unit 310 qualification. Potential extensions need to be discussed with and agreed with the commissioning authority before the IMCA continues to undertake IMCA DoLS roles after the deadline above.

Where IMCAs are undertaking case work before successfully completing the assessment for either unit 305 or 310, they must be supervised by an IMCA who has completed the relevant units. In these situations the name of the supervisor should be recorded on any IMCA reports produced.

Continued professional development

The IMCA provider will ensure that each IMCA has the opportunity to attend appropriate further training opportunities. This may include, but should not be limited to, work towards the certificate or diploma in independent advocacy, and participation in the regional IMCA networks. The minimum requirement is [14 hours] per year.

Records and monitoring

During the term of the agreement the local authority will require from the provider on a [quarterly] basis the following information for contract monitoring purposes. This is broken down into the five parts of the service as identified above [the last three being options for the commissioner]. In addition [annual] information must be provided about the staffing of the service.

1. Providing Independent Mental Capacity Advocates
An authorised instruction is defined here as the IMCA provider receiving an instruction form that is completed by an authorised person. In checking whether the person is authorised to make the instruction the IMCA provider is required to ensure that the reason for the instruction falls within the scope of the MCA.

Authorised instructions could include instructions which need to be forwarded to another IMCA provider because of the location of the person/decision.

Number of authorised IMCA instructions broken down by:

- Decision type/IMCA role – i.e. accommodation, SMT, safeguarding adult, care review, 39A, 39C, 39D.
- Age, gender, ethnicity and mental impairment (using DH categories).
- Time spent on each instruction split between direct advocacy and travel time. The advocacy time should include time spent gaining support and supervision in relation to the specific instruction. The supervisor's time should also be included here.
- Outcome of instruction: concluded, withdrawn or not concluded, broken down by reason (i.e. withdrawn as person has either capacity or someone appropriate to consult, client died, out of area, other).
- Numbers of formal challenges made by IMCA using complaints procedures or resulting in legal action.
- Records of any complaints or compliments made regarding the service.

2. Information service

- Number of contacts regarding potential IMCA instructions made, broken down by email, phone or post.
- Time spent responding to contacts
- Records of any complaints or compliments regarding the information service.

3. Awareness and training

- List of training sessions provided, including participant type, numbers, length and content of sessions.
- Participant feedback on training provided.

4. Supporting the local integration of the MCA into policy and practice

- Information about contributions to the local implementation network.
- Details of other work involved in either identifying or supporting local policy and practice issues.

5. Providing additional advocacy services

Referrals broken down by:

- Reason for referral.
- Who made the referral.
- Age, gender, ethnicity and any impairment (using DH categories in box 10 of Appendix 2).
- Time spent on each referral split between direct advocacy and travel time. The advocacy time should include time spent gaining support and supervision in relation to the referral. The supervisor's time should also be included here.
- Significant outcomes for the person.
- Numbers of formal challenges made.
- Records of any complaints or compliments made regarding the service.

Quarterly meetings will be organised to review this information and to amend and improve this specification and the IMCA provider will be expected to be a full partner in this process.

Staffing

For each IMCA:

- Name
- Units of national advocacy qualification successfully completed
- Details of continuing professional development undertaken

Management and accountability

The IMCAs will be managed by, and primarily accountable to, the advocacy organisation that recruits and employs them, thereby maintaining their independence from the local service providers.

The advocacy organisation will be accountable for the IMCA service to the commissioners. The advocacy organisation is expected to undertake regular reviews or audits of their service and to link these to their development plans. The advocacy organisation should also have a written complaints procedure, which should include a role for a person who is independent of the organisation, as either an investigator or decision-maker at an appeal stage.

The advocacy organisation will follow agreed engagement protocols [these should be added as appendices to the service specification – see example in Appendix 3]. These set out how disputes may be resolved and opportunities for the IMCA provider to raise issues in relation to IMCA instructions at a senior level within the local authority [and health trusts].

The commissioning authority will not seek to be involved in any matters of staff deployment or discipline. This includes whether a particular IMCA does or does not support and represent a specific individual.

A steering group involving the IMCA advocates and managers, representatives of the commissioners and representatives of both the health and social services providers will be organised to oversee the IMCA service. This will meet [quarterly].

An annual review of the service may be undertaken. This may be carried out by staff from the commissioning department or be commissioned externally.

The advocacy organisation should have its own internal quality assurance system, which should include standard-setting, monitoring, management and review processes, to ensure that the required service quality is maintained.

Funding

The indicative annual budget for this service is [£].

The indicative annual budget includes [£] to be set aside for any disputed case costs. This can be accessed by the IMCA provider to pay for any legal costs associated with supporting and representing individuals.

The provider will be required to provide the following information about expenditure on an [annual] basis broken down into the following categories:

1. *Direct costs of providing IMCAs to respond to instructions.* This to include case work, travel time and time spent in supervision. (The total hours of IMCAs' time should be recorded split between direct advocacy and travel time.)
2. *Administration and overheads.* To include office costs, phone, IT and travel.
3. *Management, training and supervision (the supervisor's time).*
4. *IMCA information service.* The staffing costs of responding to enquiries about accessing the IMCA service.
5. *Other activities to support the implementation of the MCA.* This could include staffing costs of any awareness-raising and training on the IMCA role, and participation in local strategic forums (for example safeguarding adults boards and MCA implementation networks).
6. Disputed legal costs. Money used to pay any legal costs incurred by the IMCA service in relation to supporting and representing individuals.

Quality indicators

These are set out for the five areas of the service specification.

1. Providing IMCAs

- Feedback from people instructing the IMCA service (see Appendix 4).
- Percentage of instructions where an IMCA report was prepared.
- Analysis of a sample of IMCA reports (see Appendix 5).
- Service user feedback (see Appendix 6).
- Details of difference made by the IMCA service broken down into: person's involvement; outcome of the decision; other aspects of care and support; practice of health and social care staff; other (see Appendix 7)
- Records of any complaints or compliments made regarding the service.
- Working towards or achieving relevant external quality marks.
- Training, qualification and supervision of IMCAs.

2. Information service

- Number of contacts responded to regarding potential IMCA instructions made, broken down by email, phone or post.
- Responses to emails and phone calls made within [two hours] during office hours. Mail responded to within [one] working day.
- Records of any complaints or compliments made regarding the service.

3. Awareness and training

- List of training sessions provided, including participant type, numbers, length and content of sessions.
- Participant feedback on training provided.

4. Supporting the local integration of the MCA into policy and practice

- Examples of work either identifying or supporting local policy and practice issues.
- Feedback from the Local Implementation Network and/or Safeguarding Board.

5. Providing additional advocacy services

Specific outcomes should be identified according to the type of advocacy service commissioned. They may include:

- service user feedback
- examples of positive outcomes for individuals which are attributable to the advocacy service
- records of any complaints or compliments made regarding the service.

Appendix 2: DH national IMCA database questions

(A) BASICS Questions marked * must be completed for all cases	
1. Local Authority*	
2. IMCA provider*	
3. Date referral received*	DD/MM/YYYY
4. Is this a first referral?* ☐ Yes ☐ No	**5. Client ID*** **Client Text** (max 30 characters)
6. Gender	☐ Male ☐ Female
7. Age ☐ 16 - 17 ☐ 18 - 30 ☐ 31 – 45 ☐ 46 – 65	☐ 66 - 79 ☐ 80 and over ☐ Not known
8. Ethnic Background	
White	☐ British ☐ Irish ☐ Other White
Mixed White	☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Other Mixed White (specify)
Asian or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian (specify)
Black or Black British	☐ Black Caribbean ☐ Black African ☐ Other Black (specify)

Chinese or other ethnic group	☐ Chinese ☐ Other ethnic category (specify)
Other	☐ Not established (for referrals only, not IMCA cases) ☐ Remind me later

9. Does the client have a disability? (choose one category only)

☐ Mental Health problems
☐ Serious physical illness
☐ Learning Disability
☐ None
☐ Not known
☐ Other general special needs (please state):

10. Nature of client's Impairment (choose one category only)

☐ Unconsciousness
☐ Autism Spectrum Condition
☐ Mental Health problems
☐ Serious physical illness
☐ Acquired brain damage
☐ Dementia
☐ Learning Disability
☐ Cognitive impairment
☐ Combination
☐ Other (please state):

11. Primary means of communication (select main category only)

☐ English
☐ Other spoken language
☐ British Sign Language
☐ Words / pictures / Makaton
☐ Gestures / Facial expressions / vocalisations
☐ No obvious means of communication
☐ Other (please state)

12. Is this client eligible for an IMCA?*	☐ Yes ☐ No

13. If NO Please indicate reason IMCA will not be assigned (select main reason only)

☐ Not eligible (has capacity)
☐ Not eligible (is befriended)
☐ Decision-maker did not instruct
☐ Supervisory body did not instruct
☐ Not eligible (not SMT, change in accommodation, care review or adult protection)
☐ Not a deprivation of liberty
☐ Other reason (please state):

14. If NO CLOSE RECORD + DATE (no more changes allowed)*

15. If YES client is eligible, when did the IMCA begin case work?* DD/MM/YYYY

(B) REFERRAL DETAILS

16. Where was the client at the time of referral? Specify name of hospital, care home etc.

☐ Own home ☐ Care home/care home with nursing (name) ☐ Hospital (name) ☐ Supported living (name)	☐ Uncertain ☐ Prison (name) ☐ Other (please state):

17. Where did the referral come from? (eg hospital discharge team, social work team, care home manager. Please identify team and location).

Specify

18. Who is the decision-maker?

☐ Doctor
☐ Social worker
☐ Other (If not doctor or social worker, state broad occupational group)
☐ Supervisory body

(C) WHAT IS THE DECISION TO BE MADE? (select one only – create new record for each decision)

19. ☐ Serious medical treatment (SMT) ➔	What is the proposed medical treatment? ☐ Cancer treatment ☐ Hip/leg operation ☐ DNAR ☐ Medical investigations ☐ Serious dental work ☐ Treatment that may lead to loss of hearing or sight ☐ ECT ☐ Major surgery (eg open heart or brain / neuro-surgery) ☐ Major amputations (arm or leg) ☐ ANH ☐ Termination of pregnancy ☐ Other (please specify)

20. Did the IMCA seek a second medical opinion? ☐ Yes ☐ No

21. Was a second medical opinion obtained? ☐ Yes ☐ No		
22. ☐ Change in accommodation ➔ (select one box from each column)	From: ☐ Own home ☐ Care home/care home with nursing ☐ Hospital ☐ Supported living ☐ Prison ☐ Other (please state):	To: ☐ Own home ☐ Care home/care home with nursing ☐ Hospital ☐ Supported living ☐ Other (please state): ☐ To be decided
23. ☐ Adult Protection		
24. ☐ Care Review		

25. ☐ Deprivation of Liberty
Please specify
☐ S39 A assessment for a standard authorisation
☐ S39 A assessment for an unauthorised deprivation of liberty
☐ S39 C Gap in appointment of relevant person's representative
☐ S39 D Support to relevant person
☐ S39 D Support to relevant person's representative
☐ S39 D Support to relevant person and their representative

(D) HOURS (complete relevant fields)

26. Hours (to nearest 10 minutes)	
With client	
With relevant person's representative	
Consulting others	
Obtaining and reviewing information	
Attending decision making meeting(s)	
Report writing	
Travel	
Other (please specify)	
Total hours on this case:	

(E) OUTCOMES

27. Was an IMCA report submitted to the decision-maker or supervisory body?	☐ Yes ☐ No

28. What was the Outcome?	SMT given: ☐ Yes ☐ No Move took place: ☐ Yes ☐ No Care review took place: ☐ Yes ☐ No Support given during adult protection process: ☐ Yes ☐ No DOL authorisation granted: ☐ Yes ☐ No DOL representation and support given: ☐ Yes ☐ No
29. If YES, please enter date completed: DD/MM/YYYY	

30. If NO report submitted, please indicate reason below

☐ Not eligible (has capacity) ☐ Not eligible (is befriended) ☐ Issue was resolved ☐ Decision no longer required	☐ Urgent decision needed ☐ Death of client ☐ Client moved ☐ Other reason (please state)

31. How well do you think <u>you</u> worked with the LA/NHS on this case?

☐ very well
☐ well
☐ not well

Comments:

32. How well do you think the <u>LA/NHS</u> worked with you on this case?

☐ very well
☐ well
☐ not well

Comments:

33. Were you able to ascertain the client's wishes or preferences in relation to the decision to be made (directly or indirectly?	☐ Yes ☐ No

34. Looking back at this case, how did you most contribute? (rank those selected where 1 = lowest and 4 is highest contribution) (select those that apply)

☐ ascertained the views of the client and fed them into the decision-making
☐ asked questions on behalf of the client to ensure they were fully represented
☐ investigated circumstances through interviews or other research to feed into the decision
☐ checking the decision-making process is in accordance with the Act

35. Where applicable, did the outcome reflect the client's wishes and preferences (so far as you were able to establish)?	☐ Yes ☐ No ☐ Partly/can't tell

	☐ N/A
36. Where applicable, was the outcome significantly affected by the involvement of the IMCA?	☐ Yes ☐ No ☐ N/A
37. Where applicable, did the IMCA challenge the outcome? Comments	☐ Yes ☐ No ☐ N/A

38. If YES, please specify route(s) taken <u>by IMCA</u> to challenge the outcome

☐ Discussion with decision-maker ☐ Discussion with other senior staff ☐ NHS complaints procedure ☐ Application to Court of Protection ☐ Discussion with Supervisory Body ☐ Discussion with Managing Authority	☐ Local Authority complaints procedure ☐ Raised with Steering Group ☐ Legal action (Please specify) ☐ Other route (Please specify)

39. Overall, how satisfied were you that your involvement provided a safeguard for this client?

☐ very satisfied
☐ quite satisfied
☐ not really satisfied

Comments

(F) CASE CLOSURE

40. CLOSE RECORD + DATE

Appendix 3: Example engagement protocol

1. Context

1.1 This document details the protocols agreed to by [local authority], [local health trusts] and [IMCA provider] and relates specifically and exclusively to the IMCA service.

2. Purpose

2.1 The purpose of this agreement is ensure that the IMCA service is made available to, and is effective to, those people who are eligible to receive it.

3. Instructions

3.1 The local authority/NHS will instruct IMCAs where there is a duty to do so under the MCA.

3.2 The local authority/NHS will use its discretionary powers to instruct IMCAs to ensure that people lacking mental capacity in relation to the relevant decisions have appropriate independent representation. The local authority/NHS will follow local policies for instructing IMCAs in these situations.

3.3. The decision as to whether an instruction should be made sits with the local authority/NHS and not the IMCA provider. This includes decisions about whether the person lacks capacity, the appropriateness of family and friends to represent them, and whether treatment is serious medical treatment.

3.4 Instructions must be made in writing by a person authorised to make the instruction.

3.5 On receipt of an instruction the IMCA provider must verify that it was made by an authorised person. The following details which people are authorised in relation to the different IMCA instructions.

- *Accommodation decisions and reviews:* an employee of the local authority or health trust proposing to make, or reviewing, the arrangements.
- *Serious medical treatment decisions:* an employee of the health trust which would provide the proposed treatment or a doctor with some responsibility for the decision.
- *Safeguarding adults:* the safeguarding manager, or an employee of the local authority or health trust with responsibility for taking the protective measures.

- *DoLS IMCA roles:* an employee of a health trust or local authority who holds delegated supervisory body functions.

3.6 Once the IMCA service confirms that the instruction was made by an authorised person the service must be provided. The IMCA provider will advise the instructor within 48 hours of instruction the name and contact details of the IMCA who will support and represent the individual.

3.7 If a different IMCA provider should have been instructed because of where the person is, the IMCA provider should advise the instructor of this as soon as they become aware of it, and ensure that the instruction is received and accepted by the appropriate IMCA provider.

3.8 If the IMCA provider has concerns whether an individual is eligible for an IMCA for any other reason than who made the instruction (e.g. the person having someone appropriate to consult) this may be raised at any time with the person making the instruction. A decision to withdraw an instruction sits with the instructor and not the IMCA service.

3.9 The instructor may at any time withdraw the instruction if they gain information that indicates that the person does not meet the statutory criteria.

3.10 Where instruction is withdrawn, the IMCA will cease representing the individual unless they have concerns about an aspect of the decision-making process. For example, if instruction is withdrawn because the person has been assessed as having capacity to make the decision the IMCA was originally instructed for, an IMCA might continue working with the person if they were challenging that assessment of capacity. If instruction is withdrawn, the IMCA's statutory rights of, for example, access to relevant records and meeting the person in private no longer apply.

3.11 Where the local authority/NHS instructs an IMCA and there are family or friends who are involved, it is the instructor's responsibility to advise them that an IMCA has been instructed and provide information about the IMCA service.

3.12 If [IMCA provider] receives an enquiry or referral in relation to someone who may meet the criteria for an IMCA instruction the following may occur:

- The IMCA provider will encourage the person to contact someone who would be authorised to make the instruction.
- The IMCA service may contact an authorised person directly to facilitate instruction.

3.13 If the IMCA service has a reasonable belief that an instruction was not made for an eligible person it may take formal action. This could include instigating a formal complaint to the appropriate body or making a safeguarding adult alert.

3.14 Decisions about which IMCA supports and represents an individual will be made by the IMCA provider. In line with the MCA Code of Practice IMCAs may hold multiple advocacy roles with an individual. This could include other IMCA roles and non-statutory advocacy.

4 IMCA reports

4.1 Written IMCA reports will be provided to the instructor for all instructions made.

4.2 The IMCA provider will, wherever possible, ensure that written reports (including interim reports where appropriate) are provided prior to decisions being made.

4.3 Where circumstances are such that time frames are very short (e.g. some serious medical treatment decisions), with the agreement of the decision-maker the IMCA will report verbally to the decision-maker and provide a written report after the decision has been made.

4.4 If the IMCA writing a report has not successfully completed the relevant units (305 and/or 310) of the qualification in independent advocacy, the report should identify the suitably qualified IMCA who has supervised the work.

4.5 The instructor will advise the IMCA of the outcome of the decisions within two weeks of making decisions.

4.6 The IMCA may ask for a written account of how regard was given to the IMCA's report or other representations (including verbal) in making decisions. This should be provided within one week where the IMCA provider identifies this as an urgent matter.

4.7 The IMCA will provide written confirmation to the instructor when they have ended their work with all individuals. This will include instructions where the instruction was withdrawn or the person died.

4.8 Any requests from other professionals, family members or friends to see IMCA reports should be addressed to the instructor/instructing body. They would need to make a best interests decision as to whether to share reports. IMCA reports may not be amended by the instructor. (Requests by any party for the IMCA provider to disclose personal records held under the Data Protection Act 1998 must be managed by the IMCA provider.)

5. Section 39A IMCA instructions

5.1 The supervisory body will instruct the IMCA provider within one working day of being alerted to the need for an S39A IMCA.

5.2 On receipt of an authorised instruction the IMCA provider will advise the supervisory body within one working day of the name and contact details of the IMCA who will support and represent the individual.

5.3 The supervisory body will ensure that all assessors and the IMCA are provided with contact details within one working day of that information being available.

5.4 The IMCA will contact the best interests assessor within one working day of being provided with their contact details.

5.5 An IMCA report will always be provided to the best interests assessor which must be considered by the assessor prior to completing the best interests assessment.

5.6 The IMCA may make representations to the supervisory body about the conditions, duration and selection of the person's representative if a standard authorisation is to be granted. The supervisory body will have regard to these representations when granting a standard authorisation.

6. Role of the IMCA

6.1 The IMCA service will be provided in line with the MCA 2005, its Regulations and MCA Code of Practice , and the DoLS Code of Practice. Therefore the IMCA will have the following roles and functions.

6.2 The IMCAs role is to:

- support and represent the person who lacks capacity
- obtain and evaluate relevant information
- ascertain as far as possible the person's wishes and feelings
- ascertain alternative courses of action.

6.3 IMCAs have the following statutory powers:

- to meet the person in private where practical and appropriate
- to examine and take copies of relevant records (as set out in 35(6) of the MCA).
- to ask for second medical opinion.

6.4 IMCAs have the right to challenge any aspect of the decision-making process, if for example they have concerns about whether decisions comply with the MCA.

6.5 To ensure timely representation, where possible the IMCA and the instructor, decision-maker or assessor will agree initial time frames. This may include when an IMCA report needs to be submitted. Maintaining communication and negotiating changes to timescales is a joint responsibility.

7. The IMCA steering group

7.1 A steering group will meet to support the availability and effectiveness of the IMCA service.

7.2 Meetings will take place quarterly with the option of arranging additional meetings as needed.

7.3 Representations will include senior managers of the local authority, NHS trusts and IMCA provider.

7.4 Steering group members will have a role in trying to resolve disputes. Their focus will be the interests of the person who is represented by the IMCA service.

8. Agreement for resolving issues in the decision making process

8.1 Resolving any disputes is a joint responsibility of both the IMCA provider and the responsible body.

8.2 It is important that those responsible for making decisions communicate effectively, in a timely manner, taking into account each other's points.

8.3 Where the IMCA has concerns about the process or outcome of a decision:

- In the first instance the IMCA should speak to the instructor/decision-maker or assessor.
- If the IMCA still feels that the issue is unresolved they should refer it to that person's manager, or a relevant senior manager in the responsible body. The IMCA provider should provide a written account of what the concerns are.
- At this stage it may be appropriate to bring the concerns to members of the IMCA steering group. The members of the steering group will endeavour to support the timely resolving of issues and may suggest appropriate people/routes for the IMCA service to pursue issues with.
- If the IMCA still feels the issue is unresolved they can use the local complaints procedure.
- As a last resort, or where delay could go against the best interests of the person, the IMCA may seek permission to apply to the Court of Protection or judicial review.

8.4 The responsible body should make an application to the Court of Protection to decide on the matter if any of the following applies:

- There is a serious dispute between a responsible body and the IMCA provider about an aspect of the decision-making process.
- The outcome could have significant consequences for the person.
- It has not been possible to resolve using local processes, or the delay to try to do so could go against the person's best interests.

8.5 If the IMCA provider initiates or is involved in any legal action in its role of supporting and representing an individual, the responsible body will not seek an award of legal costs against the IMCA provider.

9. Confidentiality

9.1 Health and social care staff who come into contact with IMCAs need to be aware that they may share relevant information.

9.2 The IMCA provider will keep all personal information securely. This will comply with the [IMCA provider's] confidentiality policy and the Data Protection Act.

10. Complaints about the IMCA service

10.1 Where a complaint is concerned with the decision to instruct the IMCA service, this will be directed to the instructing body.

10.2 Where the complaint is concerned with the conduct or quality of the IMCA service this should be made in the first instance directly to the [IMCA provider].

10.3 The IMCA provider will advise the commissioner and steering group of any complaints raised about the service and the outcomes of these.

Acknowledgement

This example service specification is based on those developed between West Sussex and Wandsworth local authorities and Advocacy Partners.

Appendix 4: Assessing quality from the feedback of instructors

The commissioner [or the IMCA provider] will collect sample feedback from people instructing the IMCA service. This will take the form of a questionnaire sent after the IMCA's work with an individual has concluded. The questionnaire will address the following:

- Overall satisfaction rating of the IMCA service.
- Did the IMCA respond in a timely way to the instruction?
- Was the IMCA able to attend key meetings?
- Were the service user's wishes, feelings, beliefs and values identified by the IMCA service?
- Was an IMCA report provided, and at an appropriate time in the process?
- Were written reports produced by the IMCA of a good standard?
- Did the IMCA's involvement have a positive outcome for the service user?
- If the outcome of the process went against the service user's expressed wishes did the IMCA robustly represent their views (e.g. by informally or formally challenging the outcome)?

Appendix 5: Assessing quality by analysing IMCA reports

The commissioner will arrange for the analysis of a sample of IMCA reports. Consideration will be given regarding the maintenance of the confidentiality of service users in undertaking this analysis. This will include the following reports:

- reports submitted to decision-makers prior to decisions being made
- reports submitted by section 39A IMCAs to the best interests assessor prior to completing the best interests assessment
- reports submitted by section 39C or 39D IMCAs when completing their work.

Quality indicators

- Does the report demonstrate the IMCA's understanding of the MCA and the IMCA role?
- Does the report satisfactorily identify the person's needs and wishes?
- Are all statements evidenced?
- Are individuals and records consulted clearly identified?
- Does the report communicate clearly what the person receiving the report should consider?
- Was the report provided at a satisfactory time in the process?

Appendix 6: Assessing quality by focusing on service user views

It is recognised that there are particular challenges to collecting feedback from the service users of IMCA services on the quality of the IMCA service. For many service users it is more useful to focus on their potential views on the outcome of the process for which the IMCA was instructed to support and represent them.

The commissioner will focus specifically on instructions where the outcome went against, or is likely to have gone against, the views of the person. In such cases the IMCA service should be able to demonstrate how well it supported and represented the person's views.

The IMCA service should specifically identify to the commissioner [and/or steering group] instructions where the outcome went against the service user's wishes and identify the steps taken by the IMCA service to represent the person's views, including informal or formal challenges.

The commissioner [and/or steering group] may wish to gain information about the action of the IMCA service in other situations where the outcome may have gone against the service user's views. For example, for accommodation instructions where the outcome was for the person to move from their own home into residential care.

Where possible the commissioner [and/or steering group] may additionally want to arrange for feedback directly from the individuals themselves.

Quality indicators

- Did the IMCA adequately represent the person's views, including in the IMCA report?
- Did the IMCA ensure that options which were closer to the person's views were identified and fully explored?
- Were the reasons that the IMCA did not continue to formally challenge the decision clear?

Appendix 7: Assessing quality by identifying the difference the IMCA service has made

The IMCA provider will collect information about the difference the IMCA service has made. This would include any differences for the person, but also wider changes in health and social care services.
The key areas in which IMCAs can make a difference are in relation to:

- how the person was involved in the decision making process or what was known about their views or wishes
- the outcome of the decision making process for the person
- other aspects of the person's care and support
- the practice of health and social care staff.

Potential outcomes are identified for each type of IMCA instruction which can be used. Each can be marked as yes/no for efficient recording. Where significant outcome are achieved specific details should be provided (i.e. a couple of sentences explaining the difference made).

These outcomes were developed by the Norah Fry Research Centre to help assess the impact of IMCA providers. The results of this research, when published, could be used to make comparisons with local IMCA providers.

For each case the following information should be recorded:

- age
- ethnicity
- mental impairment
- whether the client died before the case closed.

All instructions: how the person was involved in the decision-making process or what was known about their views and wishes

- My involvement meant that the person got extra support to help them communicate their needs and wishes.
- As a result of my involvement, the person was able to communicate relevant needs or wishes which would have been unknown otherwise.
- I used other sources (e.g. talking to other people or looking at records) to find out about important needs and wishes which would have been unknown otherwise.
- My input meant that the person attended meetings which they would not have attended otherwise.

- As a result of my work, a capacity assessment was undertaken which showed the person could make their own decisions in this area.
- I did other things that made a difference to the way the person was involved or what was known about their views and wishes.

Accommodation instructions

- My involvement in this case meant that the person stayed where they were.
- My involvement in this case meant that the person moved instead of staying where they were.
- My involvement in this case meant that the person moved to a different place to what was proposed.
- The decision makers would not have thought about the place the person moved to if I hadn't told them about it.
- My involvement meant that the person moved quicker than would have happened otherwise.
- My involvement meant that the person's move took longer than would have happened otherwise.
- My involvement meant the person avoided going to temporary accommodation before a longer term move.
- My involvement meant the person went into temporary accommodation before a longer term move.
- My involvement meant that a care review took place sooner than would have otherwise been the case.
- My involvement meant that the person was represented by an IMCA in a subsequent care review.
- My involvement as an IMCA had an impact on the accommodation decision for this person in other ways.

SMT instructions

- My involvement meant a different decision was made about the person's treatment.
- As a result of my involvement, the person received treatments that they wouldn't have had otherwise.
- My involvement meant that the person did not receive treatments that they would have otherwise been given.
- Treatment was delayed because of my involvement.
- Treatment took place quicker because of my involvement.

- My involvement as an IMCA had an impact on the serious medical treatment decision in other ways.

Safeguarding adults instructions

- My involvement meant that temporary protective measures were put in place.
- As a result of my involvement no protective measure were put in place.
- My involvement meant that different or extra protective measures were put in place.
- As a result of my involvement urgent protective measures were put in place.
- My work meant that the police were involved.
- My input meant that the police took action.
- My involvement in this case meant that an application was made to the Court of Protection.
- My work as an IMCA meant that a review of the safeguarding plan was scheduled.
- As a result of my involvement, protective measures were put in place quicker.
- My involvement meant that it took longer to put protective measures in place.
- My involvement had an impact on the outcome of the safeguarding process in other ways.

39A DoLS instructions in relation to a request for a standard authorisation. Also 39C or 39D IMCA involvement in requests for further standard authorisations

- The authorisation was not granted because of my involvement.
- The authorisation was granted because of my involvement.
- I made a difference to the conditions which were set.
- I made a difference to the length of the authorisation.
- I made a difference to the choice of the relevant person's representative.
- I avoided an urgent authorisation being extended.
- My representation helped to ensure that the urgent authorisation was extended.
- The assessment was conducted more thoroughly because of my involvement.

- My involvement had an impact on the request for a standard authorisation in other ways.

39A DoLS instructions in relation to a potential unlawful deprivation of liberty

- I ensured that the restrictions were assessed as being a deprivation of liberty.
- I ensured that the restrictions were not assessed as being a deprivation of liberty.
- The assessment took longer because of my involvement.
- The assessment was quicker because of my involvement.
- My involvement had an impact on the assessment for a potential unauthorised deprivation of liberty in other ways.

39C DoLS instructions

- The person had a better understanding of what the standard authorisation meant for them and their rights.
- The managing authority had a better understanding of the standard authorisation.
- A DoLS review was undertaken.
- An application was made to the Court of Protection.
- The person accessed a solicitor.
- My representations helped to ensure a timely application for further standard authorisation.
- The relevant person's representative was appointed quicker than would have been otherwise.
- I influenced the decision on who was appointed as the relevant person's representative.
- My involvement as an IMCA had an impact on the DoLS process for this person in other ways.

39D DoLS instructions

- The person had a better understanding of their rights and what the standard authorisation meant for them and their rights.
- The person's representative had a better understanding of the standard authorisation, their role and rights.

- The managing authority had a better understanding of the standard authorisation.
- A DoLS review was undertaken.
- An application was made to the Court of Protection.
- The person accessed a solicitor.
- I ensured a timely application for a further standard authorisation.
- My involvement as an IMCA had an impact on the DoLS process in other ways.

All instructions: differences in the person's care and support other than those directly related to the reason for IMCA instruction. (These are the key potential outcomes for care reviews)

- My involvement meant that the care provider had a written record of the person's views and wishes to inform the support they provided (this could be a copy of an IMCA report if these were included in detail).
- My involvement meant that the person had more contact with people who were important to them.
- My input meant that the person accessed new opportunities.
- The person's staffing support changed as a result of my involvement in this case.
- As a result of my work, the person was supported to make some decisions themselves.
- My input meant there were changes to how the person's money was managed or spent.
- My involvement led to another IMCA instruction being made for the person.
- My involvement as an IMCA had an impact on this person's care and support in other ways.

All instruction: differences in the knowledge or practice of health or social care staff

- At least one staff member had a better understanding of the Mental Capacity Act.
- At least one staff member had a better understanding of DoLS.
- An organisation changed some of its practice to comply with the Mental Capacity Act.
- An IMCA instruction was made for a different person.

- An application was made under the Deprivation of Liberty Safeguards for a different person.
- An alert was made under Safeguarding Adults for another person.
- My involvement as an IMCA had an impact on the knowledge and practice of health and social care staff in other ways.

Appendix 8: Suggested tender requirements

Provided below is the key information that commissioners may seek if tendering the IMCA service. Where commissioners are considering, or are required to re-tender, IMCA services attention needs to be given to the Transfer of Undertakings (Protection of Employment) Regulations 2006.

Changing IMCA provider may meet the 'service provision change' requirements of the regulations. For example, an advocate who is wholly employed as an IMCA to work in a single local authority (whether they are full-time or part-time) would be covered by the legislation. The position is less clear for advocates who undertake other work for their employer in addition to an IMCA role, or provide IMCA services across more than one local authority. (In *Hunt* v *Storm Communications Ltd* it was found that the provisions applied for an employee who spent 70 per cent of their time on the activity which was re-contracted.)

Commissioners will be familiar with the following:

- The TUPE regulations require the existing service provider to provide information to the new provider in advance of a transfer.
- Where TUPE applies, it is common practice for the transferor employer to indemnify the new employer against any pre-transfer breaches of contract or employment law.

General requirements

The provider organisation should:

- Provide information on its size, organisational structure and experience; its constitution.
- Demonstrate experience of providing advocacy, advice or information services.
- State its experience with the different client groups who may be eligible for an IMCA.
- Either demonstrate its experience of providing an IMCA service or explain how it will develop this skill.
- Show experience of working in partnership with statutory agencies.

- Illustrate experience of providing a service which demonstrates an active commitment to equal opportunities.

- Show experience of working with users from ethnic minorities, those who do not have English as their first language, those who need specialist communication tools and those who communicate through informal methods.

- Confirm that it employs staff in a manner that ensures they are fit for purpose; this would include the provision of enhanced CRB checks and ensuring IMCAs are registered with the Independent Safeguarding Authority.

- Agree to accept and work within locally agreed multi-agency safeguarding adults policy and procedures, as per *No Secrets* (2000)[4], Section 7 guidance and agree that its staff will be bound by these policies.

- Provide an annual report together with financial accounts for the last financial year, as well as details of its public and employers' liability insurance.

- Provide a copy of its confidentiality policy, or show a willingness to develop one.

- Provide details of the organisation's quality systems including any relevant external quality marks which are being worked toward or have been achieved.

Method of working

Provider organisations should also:

- Specify the number of advocates they proposes to employ as IMCAs (within the stated budget); and whether these are part-time or full-time. [Information about any Transfer of Undertakings (Protection of Employment) Regulations (TUPE) requirements should be included here by the commissioner.]

- Identify how they will efficiently manage enquiries about potential instructions.

- Identify how they will respond efficiently to a varying case load and manage both planned and unplanned absences of staff.

- Provide information on methods of working; to include information on how case work will be recorded and how often IMCAs will receive supervision and other forms of practice support.

[4] No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, Department of Health and Home Office, 2000.

Funding

The indicative annual budget for the IMCA service is [£]. This includes [£] to be set aside for any disputed case costs. Organisations will be asked to outline their costs to provide this service, within the total proposed budget, and to give a breakdown of how this is arrived at.

Headings should include:

1. *Direct costs of providing IMCAs to respond to instructions.* This to include case work, travel time and time spent in supervision. The total hours of IMCAs' time available annually for case work should be identified.
2. *Administration and overheads.* To include office costs, phone, IT and travel.
3. *Management, training and supervision (the supervisor's time).*
4. *IMCA information service.* The staffing costs of responding to enquiries about accessing the IMCA service.
5. Other activities to support the implementation of the MCA. This could include staffing costs of any awareness-raising and training on the IMCA role, and participation in the local implementation network.

About the development of this product

Background
This guidance was a joint SCIE/DH commission, based on legislation and government policy, in the context of very little research evidence (except Redley et al, 2008). The project was informed by No Secrets policy and Mental Capacity Act (MCA).

Scoping and searching
Searching was not needed for this topic, as it was based on legislation with very little published evidence (as confirmed by Project Advisory Group).

Stakeholder involvement and consultation
Project Advisory Group included key author (Redley), Association of Directors of Adult Social Services (ADASS), IMCA providers, safeguarding leads, the Public Guardian, Department of Health Mental Capacity Act & safeguarding policy and implementation leads.

Peer review and testing
The document was drafted by SCIE, and several revised versions (informed by consultation with stakeholder groups listed above) were reviewed before being agreed by the MCA Advisory Group.

Additional endorsement
The document was approved independently by ADASS as their policy statement in this area: it is jointly published by SCIE with ADASS.

Social Care Institute for Excellence
Goldings House
2 Hay's Lane
London SE1 2HB
tel 020 7089 6840
fax 020 7089 6841
textphone 020 7089 6893
www.scie.org.uk