

**THE FIRST ANNUAL REPORT  
of  
THE INDEPENDENT MENTAL  
CAPACITY ADVOCACY SERVICE**

**Year 1**

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**THE INDEPENDENT MENTAL CAPACITY ADVOCACY SERVICE:  
THE FIRST YEAR**

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## SUMMARY

1. The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service as a safeguard for people without the capacity to make certain important decisions.
2. The Act also introduced a *legal duty* on NHS and social care staff to refer eligible people to the IMCA service. The IMCA service started on 1<sup>st</sup> April 2007 and this is the report on its first year's work.
3. The Act envisaged the IMCA service being built on good practice in the independent advocacy sector. The Department of Health (DH) made a new grant available to Local Authorities working with PCTs to commission the new service from the advocacy sector; it also issued commissioning guidance. Commissioning was greatly assisted by the experience of seven pilot IMCA organisations and the Cambridge University report on the pilots.
4. A large number of existing advocacy organisations were successfully commissioned, many at short notice, to develop the new service. National IMCA training was developed and IMCAs were trained in the three months prior to April 1<sup>st</sup> 2007.
5. The role of the IMCA has been to represent and support people without capacity, and mainly without family or friends to support them, in important decisions. Five thousand, one hundred and seventy five (5,175) people received representation from the IMCA service in its first year.
6. Three thousand and forty seven (3047) of the representations were for decisions on accommodation moves; 191 people were represented in care reviews; 671 represented in decisions about serious medical treatment and 675 were represented in adult protection proceedings.
7. The Department of Health's assessment of the first year was that a great deal had been achieved.
8. Achievements for individual people included: better decision making for the most vulnerable people; a specialist service which has time for individuals who have limited capacity to communicate their wishes; a more holistic approach to decision making, particularly in the NHS; and a more rights based approach to looking at options.
9. There were also achievements which went beyond the individuals. These are about the creation of: a new form of advocacy, a new profession and a new safeguard.

10. Independent mental capacity advocacy is a specialist and very targeted, issue focussed form of advocacy. It works holistically with the whole person, but in relation to specific decisions that need to be made. Independent mental capacity advocates are a new profession with a statutory role. This role involves a duty to represent some of the most vulnerable people in society, vulnerable both due to their lack of capacity and due to their social isolation. The new profession has the right to question and to challenge and the power to identify and highlight poor individual and institutional practice, thereby providing new safeguards.
11. At the same time the Department has concerns about the following three issues:
  - i Referrals should be at a higher level for all decisions – suggesting that awareness of, or compliance with, the Act is insufficient. There are also wide geographical differences which raises concern.
  - ii Referrals for Serious Medical Treatment are particularly low across the whole country, raising concerns about the extent to which the NHS is, at present, complying with the requirements of the Act.
  - iii Gate-keeping by IMCA organisations needs to be reviewed.
12. IMCAs have been created by the Act, as a specialist resource, a new statutory addition to the health and social care economy. They have had a strong first year, demonstrating that they are able to support and represent some of the most vulnerable people. In the next year their role will be increased by more referrals and extended in many places by the campus closure programme for people with learning disabilities and by the Deprivation of Liberty safeguards. They will be expected to grow in skills, in levels of confidence and in vision. They will play an increasing part in linking two challenging agendas: the personalisation agenda and the safeguarding agenda – a task that the whole of social and health care economy is struggling with.

## BACKGROUND

### I. Introduction: The Mental Capacity Act and the IMCA Service

1. The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service.

**The Mental Capacity Act is a vitally important piece of legislation, and one that will make a real difference to the lives of people who may lack mental capacity. It will empower people to make decisions for themselves wherever possible, and protect people who lack capacity by providing a flexible framework that places people at the very heart of the decision making process. It will ensure that they participate as much as possible in any decisions made on their behalf, and that these are made in their best interests.**

Charles Falconer, Lord Chancellor, Code of Practice to the MCA, 2007

2. The Mental Capacity Act (The Act) covers a wide range of issues. It sets out a definition of a person who lacks capacity to make a decision and it sets out a clear test for assessing this. It explains what it means to be acting in the best interests of someone and describes a checklist to help people do this. It helps people plan ahead for the possibility of losing capacity. It establishes and describes the new Court of Protection and the role of the new Public Guardian, a new public office established by the Act.
3. The Act is based on five statutory principles, which are the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to.
4. The five statutory principles are:
  - i A person must be assumed to have capacity unless it is established that they lack capacity.
  - ii A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
  - iii A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
  - iv An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests.
  - v Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively

achieved in a way that is less restrictive of the person's rights and freedom of action.

5. The Act also created the Independent Mental Capacity Advocate (IMCA) service – and equally importantly - *the legal duty* to instruct the IMCA service in certain situations. The purpose of the IMCA Service is to help particularly vulnerable people who lack the capacity to make specific important decisions; it was created as a safeguard for decision making for particularly vulnerable people.
6. The duty to instruct the IMCA service was introduced in order to require the development of a partnership between NHS / social care professionals and the IMCA service. It was recognised that NHS and social care staff may not always have sufficient time to give their full attention to people who lack capacity – and in response, the IMCA service was created with the sole duty to focus on people who lack capacity.
7. The duty to instruct the IMCA service is restricted to specific decisions only. These decisions identified in the Act are: serious medical treatment and a move to, or a change in, longer term accommodation. Regulations then introduced two further decisions where an IMCA service may be instructed: adult protection situations and care reviews. For all these decisions people must lack capacity to make these decisions. Apart from adult protection cases where this criteria does not apply, eligibility is targeted to those without the support of family and friends to assist in the decision making.
8. While IMCAs could be used for *any decision* in relation to people who lack capacity which the NHS and social care wishes to have assistance for, the duty in the Act is highly targeted. It is targeted at the most vulnerable people – those who have no one to support and represent them – and the decisions which are the most common and have the most far reaching consequences for the individuals: serious medical treatment and long term moves.

## **II. IMCAs and the independent advocacy sector**

9. The Act envisaged the IMCA service being built on good practice in the independent advocacy sector. Britain has a long history of independent advocacy. This has taken many forms, and in the last 25 years it has been provided by independent advocacy organisations throughout the country. There is immense diversity in the 600 or more organisations which make up the advocacy sector. Some organisations are client specific, and for example only work with people with mental health needs or learning disabilities. Others work with people with all different needs. Most are small or medium sized organisations. Only a small number of advocacy organisations employ more than 50 advocates and many have fewer than 10.

10. The advocacy sector has built its reputation on being fiercely independent. Advocates have focused intensely on a rights based approach to their clients and have championed their rights in many different settings. Children's advocates have worked with children in care, who are living in children's homes and foster care as well as children in need, for example those with disabilities. Advocates for people with learning disabilities have worked at the forefront of assisting people to live as independently as possible, with person centred services designed around their individual needs. Advocates for people with mental health needs have been particularly active in upholding the rights of people with mental health needs who are detained in hospital.
11. Historically, advocacy organisations have also been quite independent not only of the NHS and social care sectors, but also of each other. There have been lively debates about different approaches to advocacy, about accountability and relationships with the statutory services. Only relatively recently have advocacy organisations been coming together under a number of umbrella organisations. Some exciting work has taken place in relation to the development of an Advocacy Charter identifying advocacy principles and values and Advocacy Quality Standards.
12. Advocacy has been, in theory at least, a service commissioned by both local authorities and the NHS. In practice, while local authorities and the NHS have paid for most advocacy, there has until recently been little commissioning knowledge or skills applied to these services. Short term contracts, specifying neither quantity nor quality of advocacy have been the norm. This has now begun to change, with a greater debate about specifications, outcomes and indicators – while still valuing the independence and the right to challenge and question services. This, broadly, is the context in to which the statutory IMCA service was introduced.

### **III. Commissioning the IMCA service**

13. Commissioning the statutory IMCA service was made easier by having had seven pilot IMCA organisations. The Department of Health had advertised and competitively tendered for advocacy organisations to test out the new IMCA role. Seven organisations were selected and commissioned by the Department to provide pilot IMCA services from April 2006 to March 2007. These were: Advocacy Matters, working in Cumbria, Advocacy Partners working in Sutton, Cambridge House working in Southwark, Dorset Advocacy Services working in Dorset, Pohwer working in Hertfordshire, Speaking Up working in Cambridgeshire and Skills for People working in Newcastle.
14. The pilot organisations worked without the Mental Capacity Act, which had passed through Parliament but had not yet come into force. This



meant that they spent a great deal of time having to explain their role, explain the situations in which they should be instructed and a great deal of time raising awareness of the Act. This led to a slow start in terms of number of referrals received. However it also meant that these seven areas were much better prepared for the Act when it did come into force, and NHS and social care staff were more knowledgeable about the principles and the other provisions of the Act.

15. The pilot organisations met once a month to discuss the new IMCA role, to learn from each other and to hear from other speakers such as the Official Solicitor. These monthly meetings were useful to the advocacy organisations but also to the Department. The learning from these discussions was fed directly into the writing of the IMCA chapter in the MCA Code of Practice; it also led to one of the pilot organisations writing a short guide to the IMCA service; and the work was also the subject of a research report by Cambridge University. It was this last report that proved valuable both to commissioners of the new IMCA service, who understood better what they were commissioning, and also to the advocacy services across the country who understood more clearly the new statutory role they were going to carry out.
16. The Department then produced commissioning guidance for local authority commissioners who were working with their local PCTs to commission the service. ADASS assisted in producing the guidance. This guidance identified key issues in commissioning this service, while being non prescriptive. It identified, for example, the importance of requiring a good understanding of '*non instructed*' advocacy, which is the cornerstone of advocacy with people who lack capacity to make decisions. The Department issued a Local Authority Circular, which explained the main requirements of the Act and which announced the budgets that were being made available.
17. Local authority commissioners had, in the end, six months to commission the IMCA service. Most rose to the challenge admirably, choosing their own ways of ensuring that there was an IMCA service in each area. Most commissioners advertised and held interviews. Some commissioners offered the contract to advocacy organisations they already had contracts with. Most chose one organisation. Some however chose to offer the contract to several organisations. A few commissioners chose to work together and commissioned an IMCA service across several areas. The West London consortium, across eight London boroughs, was the biggest of these groupings.
18. In some areas the decision making process took a long time with a timetable culminating in elected members making final decisions. While some advocacy organisations knew months in advance they had been selected and were able to plan, recruit and train staff, others were told a couple of weeks in advance and some others days before they started work. Despite this mix of methods, and last minute uncertainty in some areas, one or more IMCA organisations were commissioned and ready

for work on Monday, April 2<sup>nd</sup> 2007 in each of 150 councils with social services responsibilities in the country.

19. Advocacy organisations are traditionally responsible for organising advocacy training for their own staff. The Act however required IMCAs to have specific IMCA training and to have undertaken it before they started practicing as an IMCA. This meant that IMCA training needed to be developed nationally, again based partly on what had been identified through the experience of working with the pilot organisations. The Department advertised and chose a consortium of organisations led by Action for Advocacy to develop the new IMCA training course. The Department also then decided to pay for all the IMCAs to undertake this training for the first year, to ensure that all IMCAs had the same training before they started work as IMCAs.
20. The period January-March 2006 was extremely busy as despite the decision to delay the implementation of the majority of the Act until October 2007 it was decided to continue with the previously announced date of April 2007 for the commencement of the IMCA service. Throughout this period advocacy organisations were selected; their contracts negotiated and agreed; advocates were recruited and 400 IMCAs undertook the four day IMCA training in regional training courses.

#### **IV. The IMCA role**

21. The IMCA's role is to support and represent a person in decisions being made by others on their behalf. The IMCA meets with the person and tries to establish the person's past and present wishes; their feelings, beliefs and values. This sometimes involves verbal communication and discussion. Where this is not possible, for example if a person is severely disabled with no speech, it involves communication using other means, such as pictures or signs. Sometimes little or no direct communication is possible. Then the role is to find out as much as possible about the person from relevant records and from other people who have known the person.
22. The other part of the role is to examine the decision making process. For example the IMCA's role involves ascertaining if the decision maker has given 'all practical and appropriate support' to help the person who lacks capacity to be involved as much as possible in decision making. If the person has communication difficulties, the IMCA's role may involve asking if the decision maker has obtained any specialist help, such as the help of a speech and language therapist.
23. IMCAs work to gather as much information as possible. The IMCA has a right to access relevant information in NHS and in social care files. The IMCA interviews people they consider relevant. IMCAs then write a report bringing all this information together and thereby feeding into the

decision making process. The decision maker has to consider the report, as part of determining the person's best interests.

24. No specific research was undertaken for this report on the first year of the IMCA service. However IMCAs met in regional network meetings once a quarter, facilitated by the Care Services Improvement Partnership (CSIP) MCA leads and these meetings identified some themes, and some quotes are used here to illustrate the role. In addition the Department started to develop a database to collect statistical information on cases; this remains work in progress, but all the statistics are from that database.

## OVERALL NUMBERS

**Five thousand, one hundred and seventy five (5175) people who lacked capacity were represented by the IMCA service in its first year.**

25. Five thousand one hundred and seventy five people who lacked capacity were supported and represented by the IMCA service. These are divided into the four decision types: accommodation moves, reviews, serious medical treatment and adult protection and are examined separately.

## Accommodation Moves and Reviews

26. The Act imposes a duty on NHS bodies and local authorities who are responsible for longer term accommodation decisions to involve an IMCA. This applies to people who lack the capacity to make the decision, who have no friends or family to support them in the decision making; and whose hospital stay will be for longer than 28 days or where they will be 8 weeks or more in a care home or other form of arranged accommodation.
27. The most frequent type of referral received by IMCAs in the last year was for accommodation moves. IMCAs represented three thousand and forty seven (3047) people in relation to decisions being made about their longer term care moves. The largest proportion of these decisions involved people who were in hospital, at the time (1165 people), followed by 859 moving from care homes and 679 from their own homes.
28. The IMCAs reported that they explored thoroughly whether people wished to remain in – or return to - their own homes in the community. They used pictures and symbols where words did not work. They were mindful of the fifth principle of the Act, which required all decisions to be

effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

29. Some people did communicate that they wanted to go back to their homes, and sometimes the IMCAs' reports assisted the development of a very 'person centred' intensive home based care package. There were some remarkable outcomes where some people were enabled to return home despite having limited capacity to look after themselves without very intensive support. In many other situations it was a case of finding the most appropriate care home setting. One IMCA service, fed up of being told there was no choice and that people needed to move into the first available bed, negotiated a situation where best interests decisions needed to bring two specific options to the table. They were unwilling to rubber stamp 'best interests decisions' without a genuine choice of placements occurring.
30. Reviews were introduced in the regulations as decisions where IMCAs could be invited to be involved, without there being a duty to instruct them. The rationale for this was to create a second opportunity for reviewing whether an accommodation move really had been in the best interests of a person who had not been able to consent to it. The expectation was that local authorities would develop policies identifying where this was most useful and offer clear guidance to their staff. Few appear to have done so.
31. One hundred and ninety one referrals were made for care reviews. This is a low number compared to the number of accommodation moves.

## **Serious Medical Treatment**

### **Definitions**

32. Section 37 of the Act imposes a duty on NHS bodies to instruct an IMCA whenever they are proposing to take a decision about 'serious medical treatment', or proposing that another organisation (such as a private hospital) carry out the treatment on their behalf. This duty applies if a) the person does not have the capacity to make the decision themselves and b) there is no one available to consult (such as friends or family) about the decision.
33. The Regulations defined serious medical treatment as treatment which involves giving new treatment, stopping treatment or withholding treatment, where there is a fine balance between the likely benefits and the risks; or where a decision between a choice of treatments is finely balanced; or what is proposed is likely to have serious consequences.
34. This definition was reached after extensive discussions with representatives of medical organisations, who agreed that no definition can set out a list of which treatment is 'serious' and which is not. A

judgement is required, a judgement that doctors will generally be able to make either on their own or with colleagues.

35. The duty is to instruct an IMCA – i.e to refer a patient to an IMCA and then to take into consideration the IMCA's report about the person's wishes and preferences. The decision whether or not to carry out the serious medical treatment remains the decision of the doctor, consultant or medical team.

## Referrals

36. The experience of the pilot organisations was that there were limited numbers of referrals for serious medical treatment. One possible explanation was that there was some reluctance from the medical profession to refer their patients to advocates. Another possible explanation was that the pilots were acting prior to the implementation of the Act and there was probably limited awareness of the Act.
37. The first year of the statutory IMCA service had similarly disappointing levels of referrals from the NHS for serious medical treatment.

### Referrals for Serious Medical Treatment

**Six hundred and seventy five people were referred to the IMCA service for representation in relation to serious medical treatment in England during the year April 2007-March 2008. This is an average of four and half cases per PCT in a year – or one every three months.**

38. The low rate of referral was discussed at the network meetings by commissioners, by IMCAs and by the CSIP MCA leads. The following explanations were suggested:
  - i Some doctors do not understand that there is a statutory duty to make referrals. They perceive it as discretionary.
  - ii Some doctors do not agree with the statutory duty to make referrals. They choose to disregard it.
39. There is some evidence to substantiate the first explanation. IMCAs report that they have carried out large amounts of awareness raising however there appears to be many more staff at all levels who need further training in the MCA. The solution to this problem is continued awareness raising about the Act and the duties in it.
40. There is also some evidence to substantiate the second explanation. There are reports of some doctors dismissing the idea that advocates have anything to contribute to decision making about medical treatments. There are some examples of doctors who think a discussion

with a non medically qualified person is a waste of their time and that IMCAs can have nothing to add to a medical decision making process in relation to people who have no capacity to consent.

41. On the other hand there were six hundred and seventy five doctors who did make a referral to an IMCA. The overwhelming feedback from these appears to be that IMCAs do have a part to play in decision making about serious medical treatment. For some decisions it is a modest part, mainly asking questions about the proposed treatment. It may focus mainly on a checking process that 'the person' has been considered as much as the disease. For others it is a larger part, where the information about the person – his past wishes, his preferences, his desired quality of life – helps the decision making medical professional make the decision when the decision is, as the definition states, finely balanced.
42. And finally there are some consultants who have been very clear that they value working in partnership with the IMCA service. They value having someone who has the time to focus on 'their patient' as a person with unspoken choices, preferences and wishes. They value the fact that someone has identified these wishes where possible and summarised them and this plays a part in the decision making, the same way that the relative or friend would.

## **ADULT PROTECTION**

43. Regulations enable local authorities and NHS bodies to instruct an IMCA to support and represent a person who lacks capacity where a) it is alleged that the person is or has been abused or neglected by another person; or b) where it is alleged that the person is abusing or has abused another person. This means that if they lack capacity, both victims and perpetrators can benefit from the support of the IMCA service. Furthermore there is no requirement for the person to have no family or friends in this situation. The involvement of an IMCA in this situation is a power rather than a duty, and ADASS helpfully produced a national policy statement highlighting the types of adult protection cases where IMCAs would be most useful.
44. Six hundred and eighty one (681) people benefited from having an IMCA in adult protection cases in the last year. IMCAs reported that adult protection cases were some of the most complicated cases. It was not always clear when the IMCA role should start or finish; it was not always clear how to balance supporting the collection of evidence with supporting the person; it was rarely easy working with families who may have been involved in the alleged situations. As a result a small piece of research was commissioned to examine these issues and this will be reported on in the autumn of 2008.

## ACHIEVEMENTS

45. IMCAs reported that in most areas referrals had been slow to start. Initially not many NHS and social care staff understood the duty to refer, and there was a general impression that advocates were optional resources. Furthermore even when staff understood that they were not optional but there was a duty to refer, they understood the duty to be someone else's duty. In the NHS, many nurses would not refer because they saw it as a doctor's role; while many doctors did not do it because it was as seen as a non medical role and therefore not their role. Protocols setting out whose specific task it was to pick the phone up to make a referral were slow to be developed.
46. IMCAs reported that they worked very hard to '*win over staff*', to do a lot of awareness raising, '*to get known*' and to create a '*mind shift*'. These experiences were fairly universal, and partly reflected the creation of any new statutory role, and partly seemed to reflect that some NHS and social care staff felt challenged by the idea of the new role. For the NHS their doubt was whether a non medically qualified advocate could contribute meaningfully to a medical decision. For social care the challenge was if social work was about advocating for clients, what would an IMCA be doing that a social worker wasn't?
47. When asked at the end of the year what the IMCAs were most proud of, several said *the relationships they had built*. Many reported that there had been suspicion first, but that was gradually disappearing. '*We have edged our way to where people didn't want us to be*'. Some thought they were sometimes more successful than other times: '*We are still sometimes seen as a thorn in the flesh*'; others reflected about the world of mental impairment: '*It is a humbling experience*' and '*I am the most experienced thing they have got*'.

### IMCAs were asked about their successes:

- **Our reports have a Massive Heading: Wishes and Feelings. That concentrates everyone's mind.**
- **We are proud of working with people who have no-one**
- **We ask questions like a relative; consultants like seeing us like a relative; it is less threatening;**
- **We are growing in confidence – getting better at our role all the time;**
- **It is nice to see people asking each other – does this person need an IMCA?**
- **After doctors have spoken to us a couple of times they relax and agree that hospital decisions become richer**
- **It is a humbling experience...My local authority is now launching three criminal prosecutions with IMCAs involved**
- **My success is about constantly dispelling old myths around lack of capacity**
- **We are making social and emotional needs more visible. The discussion is no longer about a bed it is about a person.**

48. We also asked IMCAs what they had found difficult during the year. Most reported that they were more experienced in working with social workers and care managers than with doctors and it was often difficult to *'engage with the acute sector.'* Some reflected that *'Some cases are very sad – it is so easy to get lost in the system if you have a mental impairment'* and others reflected: *'Some of our clients die while we are working with them'*. Still others thought: *'Safeguarding cases are difficult, constantly battling with decision makers about whether they are following their procedures'*

**IMCAs were asked about their difficulties:**

- **Difficulties engaging with the acute sector;**
- **Some of the practices are very widespread: for example consent forms need to be signed so the practice is that anyone can sign them;**
- **The excuses: “ a client acquiesces and therefore does not need an IMCA”;**
- **Not wanting to go into a care home is seen as an impairment or disturbance;**
- **Doctors know very little about the world of accountability.**
- **There is still major confusion about assessments of capacity- “We are told they can only be done by the Director of Nursing or by Consultant Psychiatrists”.**
- **The role of panels is problematic. They don't read reports and they focus only on the money.**
- **In Oxfordshire care homes have started saying to us that hospitals are telling them never to call an ambulance again for certain people.**

49. What did they want to do better? Some wanted to target places that did not make any referrals. Some wanted to work with hospitals and social services to develop better procedures to make it clear who was responsible for the referrals. Others wanted to challenge 'the lack of choices' arguments. Some IMCAs were worried about the Do Not Attempt Resuscitation (DNAR) practices they had witnessed. Some wanted to be more proactive about ensuring that they were called back to take part in the reviews of people where the original decision was finely balanced. Some wanted to make better use of their steering group, to address quality of care issues for people with impairments.
50. Looking back, all IMCAs thought that in some cases, although not in all, they had achieved a difference for the people they were representing. For example, one highlighted that an elderly lady had been in hospital for six months, with no verbal communication, without staff realising that she could 'sign'. After the IMCA highlighted this in her report, it changed the entire health plan for the person concerned. In several examples IMCAs reported that they had found long lost relatives simply by taking



several hours to go through long case records, and this resulted in changing the status of several people from complete isolation to being part of a wider family network.

51. In other examples, the IMCA reported that simply their presence at best interests meetings allowed greater care in decision making. Staff understood much better the person they were making a decision about and took the time to explore options that went some way towards meeting their needs. There were several examples of IMCAs reporting that their questions had led care home managers to review some practices, in particular in relation to end of life care. For example the home which had been placing 'DNAR' notices on the individuals' wardrobes not only stopped doing this but arranged a meeting with local doctors to develop a clearer and better care policy. Further examples are presented in the case study section of this report.
52. In one group discussion, IMCAs were asked to identify two characteristics of the IMCA role. After a lot of debate, two interesting and conflicting features were identified. Firstly, there was a sense of *power*. Many IMCAs were experienced advocates who had been working as advocates for a long time. They commented that the new statutory IMCA role was a powerful one. They felt empowered to ask for information; they felt empowered to ask questions about the practice they saw; they felt empowered to give their assessment of the wishes and feelings of their clients, many of whom were otherwise very vulnerable and due to their communication needs, at risk of not being 'listened' to.
53. Secondly, some IMCAs commented there was equally a sense of '*powerlessness*' towards the end of the role. Having asked the questions, identified the wishes and feelings, attended a best interests decision making meeting and made the case for what the person needed, it often lead to a 'dead-end'. There appeared often to be no care home that empowered the man with the very challenging behaviour to live as independently and responsibly as possible – there were only homes which locked all the doors around people with challenging behaviour. There appeared to be no mechanism for commissioning a residential care placement which included taking an elderly gentleman to the pub on a Sunday to keep in touch with his friends of 80 years. Often there were no choices of residential placements at all.

#### **ACHIEVEMENTS FOR INDIVIDUALS**

- **Better decision-making for the most vulnerable people**
- **A specialist service which has time for individuals who have limited capacity to communicate their wishes**
- **A more holistic approach to decision-making, especially in the NHS**
- **A more rights based approach to looking at options**

## ACHIEVEMENTS BEYOND INDIVIDUALS

- A new profession with a right to question
- A new profession with the right to challenge
- A new profession able to identify and highlight poor individual practice
- A new profession able to identify and highlight poor institutional practice
- A specialist mental capacity resource
- A safeguard

## PROBLEMS / ISSUES

54. Again, we must emphasise that no research was carried out with commissioners or others about any concerns they may have had about the IMCA service in their area. However, we did meet commissioners at various meetings and events, some organised by the CSIP MCA leads, and they did raise some issues. The four most frequent issues raised were gate-keeping; time taken to respond to or complete the IMCA role; quality of reports; amount of supervision/ management oversight.
55. By far the most frequent issue raised was the IMCA services' role in gate-keeping. The IMCA organisations' view was that the Act defined very narrowly who was eligible for the IMCA service. IMCA organisations were aware that when the service first started there was little understanding about the Act overall, and even less about the specific eligibility criteria amongst the people making the referrals in the NHS and in social care. As a result many of the IMCA organisations devised referral forms and referral processes which asked the referring staff a large number of questions, some of which required evidence (e.g. an assessment of capacity).
56. The view of some commissioners was that this ended up with large numbers of people being judged not eligible by the IMCA organisation, rather than by the referring organisations and some staff were deterred from making referrals because it was too bureaucratic. They reported that some NHS and social care staff felt too much 'paperwork' or information was needed before a referral could be made, and some felt interrogated about people they knew little or nothing about. They also reported that the time-scales for a move or for serious medical treatment needing to occur did not allow such referrals to be made in time and so were not made at all. The issue of gate-keeping will need to be looked at in the near future.
57. No other issue was raised as frequently. A few commissioners raised the question whether IMCAs always responded fast enough to referrals, although the large majority thought they did. A larger number of commissioners reported delays in relation to IMCA reports. There were some concerns about the quality of reports and also about whether all

IMCAs received sufficient supervision. These issues were being addressed and resolved as a normal part of local contract monitoring.

## CONCLUSION

58. IMCAs were created by the Mental Capacity Act, as a specialist resource, a new statutory addition to the health and social care economy. They have had a very strong first year, demonstrating that they are able to support and represent some of the most vulnerable people. In the next year their role will be increased by more referrals – possibly many more referrals, which may well prove a challenge to the staffing and management of the service. Their role will also be extended in many places by the campus closure programme for people with learning disabilities and, at the end of next year, by the Deprivation of Liberty safeguards. They will be expected to develop greater consistency, in terms of providing a truly national service with comparable high quality standards. IMCAs will be expected to grow in skills, in effectiveness, in levels of confidence and in vision. They will play an increasing part in linking two difficult and challenging agendas: the personalisation agenda and the safeguarding agenda – a task that much of the social and health care economy is struggling with.
-

## Quotes

### What IMCAs are most proud of

- The relationship that can be built with clients/ carers in a relatively short time in order to inform the decision making process.
- The knowledge that we have been able to influence some decisions that otherwise may have been different without our input
- The fact that the most vulnerable members of society are getting a voice which is being respected
- Proud of ourselves for setting up, running and now expanding a service that twelve months ago was just an idea. We feel we have made a huge achievement in a short time.

### Awareness raising work

We have run several awareness sessions across the county to a variety of service providers. We still have many more to do to spread the message that IMCA is a statutory service which must be used when the criteria are met and not as a voluntary or last minute option. We prefer to take the view that continuing education and promotion of the service is more worthwhile than complaints against providers who may genuinely be unsure of the IMCA service specifically and the Mental Capacity Act in general. Sessions we have provided are to:-

- General Hospital A
- General Hospital B: Consultants; and separately Social Work Department
- All Care Management groups in the LA
- LD respite unit
- 2 Brain Injury Units
- Sustaining Adults Team
- Dementia Conference
- Deprivation of Liberty Conference
- NHT induction programme to all new entrants, twice monthly.
- Private hospital
- Mental Health Advocacy
- Two mail shots to all GP practices within LA area
- Care Home project currently underway to visit all care homes in the county and provide awareness training.

The overall impression is that there was a total lack of awareness and that professionals did not understand the Mental Capacity Act in general and the legality of needing to appoint an IMCA. There was a complacency that MCA implementation did not matter until October 07. Acute Hospitals still think that there are more important risk areas than compliance with the MCA. Professionals think no-one will enforce non-compliance with the MCA. There are several capacity issues still being decided on "condition" or "label" than the principle that a person has capacity unless proven otherwise. There is a lot of

debate amongst professionals as to who is the 'Decision Maker' as people do not want to take ultimate responsibility and try to quote Multidisciplinary Team Meetings, or even that the "Primary Care Trust" is the Decision Maker. A lot of education is still required.

## **National IMCA Referral Figures**

April 2007 – March 2008

The data included in this report has been collated using The Information Centre online data tool. The report uses IMCA referral data from authorities in England, which has been input from the beginning of April 2007 to the end of March 2008.

### **Contents**

1. Eligible and non-eligible statistics
2. Monthly referral rates
3. Demographic information
4. Decision-makers
5. Serious medical treatment decisions
6. Accommodation decisions
7. Adult protection, care reviews, and other decisions
8. Report submission
9. Hours spent on each case
10. Evaluation of collaborative working and IMCA input

## 1. Eligible and non-eligible referrals

In total, 7336 were made to the IMCA service throughout England. Of these, 5179 were eligible (70.6%).

Table 1 contains the number of eligible and non-eligible referrals logged for each month between April 2007 and March 2008. The proportion of referrals that were non-eligible are represented graphically in figure 1. In general, it seems that there has been a gradual decrease in the proportion of non-eligible referrals made to the IMCA services.

*Table 1. Number of eligible and non-eligible monthly referrals*

	Eligible	Non-Eligible	Total
Apr-07	219	120	<b>339</b>
May-07	349	179	<b>528</b>
Jun-07	388	191	<b>579</b>
Jul-07	428	204	<b>632</b>
Aug-07	448	162	<b>610</b>
Sep-07	428	193	<b>621</b>
Oct-07	539	209	<b>748</b>
Nov-07	532	206	<b>738</b>
Dec-07	386	181	<b>567</b>
Jan-08	544	232	<b>776</b>
Feb-08	472	171	<b>643</b>
Mar-08	446	109	<b>555</b>
<b>Total</b>	<b>5179</b>	<b>2157</b>	<b>7336</b>

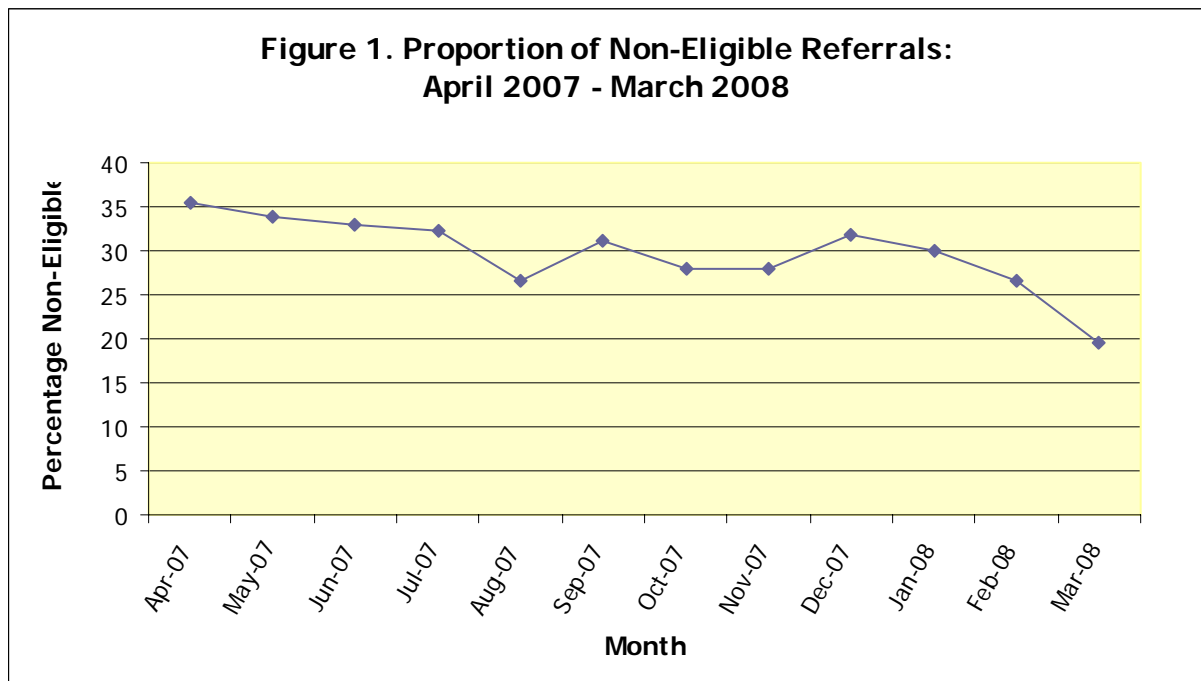


Table 2 shows the reasons why cases were not eligible for the IMCA service.

*Table 2. Reasons for non-eligibility*

	Count	%age
Befriended	869	40.29
Has Capacity	327	15.16
No Instruction	125	5.80
Not SMT, Accommod etc	342	15.86
Not Specified	12	0.56
Other	482	22.35
<b>Total</b>	<b>2157</b>	<b>100.00</b>

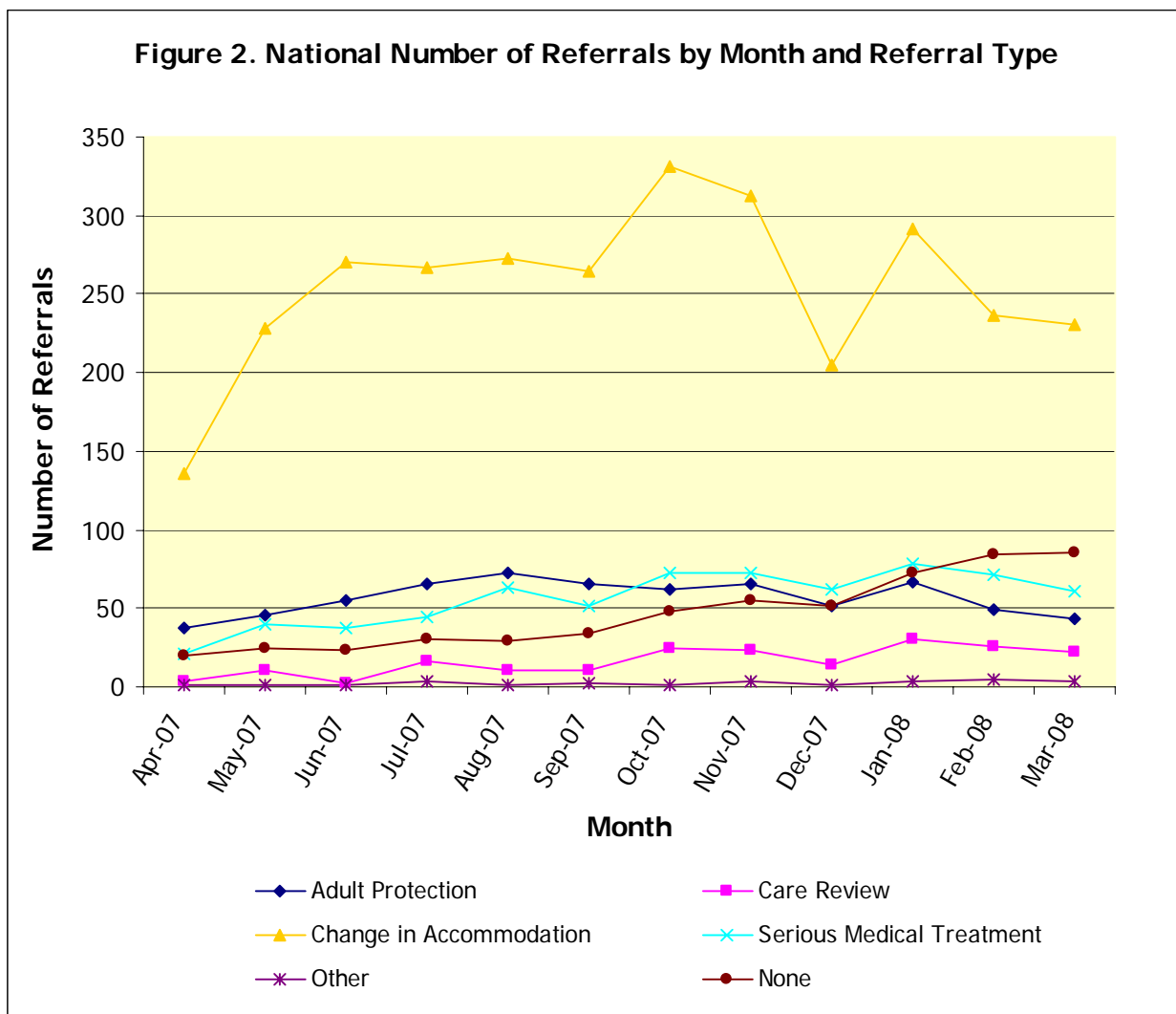
## 2. Monthly referral rates by decision type

Table 3 contains monthly referral figures over the year for each decision type. It can be seen that the most common decision was for 'change in accommodation'. In comparison to other referral types, care review cases were very low. These figures are also represented graphically in figure 2. The rate of referral throughout the year seems to have stayed relatively consistent, at an average of 440 referrals per month.

*Table 3. Number of eligible referrals for each decision type per month*

	Adult Protection	Care Review	Change in Accommodation	Serious Medical Treatment	Other	None	Total
Apr-07	38	3	136	21	1	20	<b>219</b>
May-07	46	10	228	40	1	24	<b>349</b>
Jun-07	55	2	270	37	1	23	<b>388</b>
Jul-07	66	16	267	45	3	31	<b>428</b>
Aug-07	72	10	273	63	1	29	<b>448</b>
Sep-07	65	11	265	51	2	34	<b>428</b>
Oct-07	62	24	331	73	1	48	<b>539</b>
Nov-07	66	23	312	72	4	55	<b>532</b>
Dec-07	52	14	205	62	1	52	<b>386</b>
Jan-08	67	30	292	79	4	72	<b>544</b>
Feb-08	49	26	237	71	5	84	<b>472</b>
Mar-08	43	22	231	61	4	85	<b>446</b>
<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>675</b>	<b>28</b>	<b>557</b>	<b>5179</b>





### 3. Demographics

Table 4 contains information regarding the gender, age, and ethnic background of the clients referred to the IMCA service. It also presents data regarding the nature of the clients' impairment and the place they were living at the time the referral was made.

Most referrals were received for men and women over the age of 46 who were of 'White British' ethnic origin and who were living in a care home or hospital at the time of referral.

Table 4. National demographics of eligible referrals for all decision types

		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	Unknown	Total	%
Gender	Male	274	89	1430	11	336	259	2399	46.3
	Female	407	101	1613	17	339	294	2771	53.5
	Unknown		1	4			4	9	0.2
	<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100.0</b>
Age	16 - 17	2		12			1	15	0.3
	18 - 30	82	11	93	2	37	31	256	4.9
	31 - 45	81	14	239	2	97	55	488	9.4
	46 - 65	138	43	683	5	226	142	1237	23.9
	66 - 79	130	45	797	9	149	127	1257	24.3
	80 and over	230	74	1141	10	142	140	1737	33.5
	Not known	18	4	82		24	61	189	3.6
	<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100.0</b>
Ethnic Background	Not Specified	15	4	57		8	30	114	2.2
	White British	570	163	2518	26	563	434	4274	82.5
	White Irish	15	2	88		11	7	123	2.4
	White Other	16	9	117	1	20	18	181	3.5
	White + Black Caribbean	1		10		4	3	18	0.3
	White + Black African		1	8		2		11	0.2
	White + Asian	2		5		1	2	10	0.2
	Mixed White Other			4		1		5	0.1
	Asian British or Indian	7	3	15		3	4	32	0.6
	Asian British or Pakistani	10	3	15		1	6	35	0.7
	Asian British or Bangladeshi	4		8		1	3	16	0.3
	Other Asian	8		12		5		25	0.5
	Black British / Caribbean	4	1	63		18	11	97	1.9
	Black British / African	4		23	1	6	6	40	0.8
	Other Black	2		6		3		11	0.2
	Chinese	2	1	3		5		11	0.2
	Other Ethnic Category	3	1	19		6	4	33	0.6
Not Established	18	3	76		17	29	143	2.8	
<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100.0</b>	
Nature of Client's Impairment	Acquired Brain Damage	45	9	150	1	27	21	253	4.9
	Autism Spectrum Condition	24	10	64	1	13	13	125	2.4
	Cognitive Impairment	45	16	229	1	27	37	355	6.9
	Combination	28	9	161	5	40	27	270	5.2
	Dementia	268	77	1272	10	129	163	1919	37.1
	Learning Disability	150	38	532	5	221	139	1085	20.9
	Mental Health Problems	72	19	385	4	104	74	658	12.7
	Not Specified	4	1	52		6	45	108	2.1
	Other	22	9	114		23	22	190	3.7
	Serious Physical Illness	23	3	87		64	14	191	3.7
	Unconsciousness			1	1	21	2	25	0.5
	<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100.0</b>
Place of residence at the time of referral	Not Specified			3		3	1	7	0.1
	Own Home	197	15	261	9	59	15	556	10.7
	Care Home	265	119	926	7	217	42	1576	30.4
	Hospital	126	38	1466	9	320	57	2016	38.9
	Supported L	35	7	162		39	10	253	4.9
	Uncertain	1		10		1		12	0.2
	Prison	1				3		4	0.1
	Other	29	5	148	1	14	12	209	4.0
	N/A	27	7	71	2	19	420	546	10.5
	<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100.0</b>

#### 4. Decision makers

In most cases, with the exception of serious medical treatment cases and cases where the type of decision was not recorded, a social worker took on the role of the decision maker. For serious medical treatment referrals a doctor was identified most often as the decision maker. For the vast majority of cases where the type of referral was not stated (i.e. those cases in the 'none' column) the decision maker was unknown.

*Table 5. Decision maker for each eligible referral type*

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Doctor	19	26	270	5	478	23	<b>821</b>	<b>15.9</b>
Social Worker	538	126	2202	17	51	87	<b>3021</b>	<b>58.3</b>
Other	94	31	497	4	123	20	<b>769</b>	<b>14.8</b>
Unknown	30	8	78	2	23	427	<b>568</b>	<b>11.0</b>
<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100</b>

#### 5. Serious medical treatment referrals

Six hundred and seventy five eligible referrals for a serious medical treatment decision were made to the IMCA services. The types of medical treatment involved in the decisions are shown in the table below.

*Table 6. Types of serious medical treatment*

	Open	Closed	Total Count	%
Affecting Hearing/Sight	3	7	<b>10</b>	<b>1.5</b>
ANH	6	10	<b>16</b>	<b>2.4</b>
Cancer Treatment	40	30	<b>70</b>	<b>10.4</b>
DNAR	26	37	<b>63</b>	<b>9.3</b>
ECT	2		<b>2</b>	<b>0.3</b>
Hip / Leg Operation	9	16	<b>25</b>	<b>3.7</b>
Major Amputations	2	6	<b>8</b>	<b>1.2</b>
Major Surgery	21	17	<b>38</b>	<b>5.6</b>
Medical Investigations	41	66	<b>107</b>	<b>15.9</b>
Not Specified	29	18	<b>47</b>	<b>7.0</b>
Other	113	139	<b>252</b>	<b>37.3</b>
Pregnancy Termination		4	<b>4</b>	<b>0.6</b>
Serious Dental Work	12	21	<b>33</b>	<b>4.9</b>
<b>Total</b>	<b>304</b>	<b>371</b>	<b>675</b>	<b>100</b>

In 1092 SMT cases a second opinion was sought and in the vast majority of these cases a second opinion was obtained (96.9%). Unfortunately the database provides us with no further information on what the

second opinion was regarding e.g. whether it was about the individual's capacity to make the decision or whether it was about the medical treatment in question.

*Table 7. Number of SMT cases where second opinion sought*

	Count	%
Second Opinion Sought	192	28.4
Second Opinion Not Sought	483	71.6
<b>Total</b>	<b>675</b>	<b>100.0</b>

*Table 8. Number of SMT cases where second opinion obtained*

	Count	%
Second Opinion Obtained	186	96.9
Second Opinion Not Obtained	6	3.1
<b>Total</b>	<b>192</b>	<b>100.0</b>

## 6. Change in accommodation referrals

A total of 3047 eligible referrals were logged as accommodation decisions by the IMCA services. At the time of writing 34.9% (1064 cases) of these were still open and 65.1% (1983 cases) of them had been closed. Table 9 shows where the client was moved from and where the client was moved to. Most people being moved from their own home or hospital were moved to a care home (69.5% and 65.6% respectively). Many people moving from 'other' accommodation were also moved to a care home (36.8%). Sixty four percent of people being moved from a care home were being moved to another care home. Most people moving from supported living were moving to either a care home (38.1%) or another supported living placement (27.9%).

In many cases the place where the client was moving to was undecided at the time of inputting the referral into the IMCA system.

Table 9. Accommodation moves: 'from' and 'to'

From:		To:	Count	%
Own Home		Own Home	3	0.4
		Care Home	472	69.5
		Hospital	4	0.6
		Supported Living	37	5.4
		TBC	150	22.1
		Other	13	1.9
		<b>Total</b>	<b>679</b>	<b>100.0</b>
Care Home		Own Home	49	5.7
		Care Home	552	64.3
		Hospital	2	0.2
		Supported Living	57	6.6
		TBC	188	21.9
		Other	11	1.3
		<b>Total</b>	<b>859</b>	<b>100.0</b>
Hospital		Own Home	41	3.5
		Care Home	764	65.6
		Hospital	14	1.2
		Supported Living	38	3.3
		TBC	289	24.8
		Other	19	1.6
		<b>Total</b>	<b>1165</b>	<b>100.0</b>
Supported Living		Own Home	3	1.5
		Care Home	75	38.1
		Supported Living	55	27.9
		TBC	56	28.4
		Other	8	4.1
		<b>Total</b>	<b>197</b>	<b>100.0</b>
Other		Own Home	8	6.4
		Care Home	46	36.8
		Hospital	1	0.8
		Supported Living	16	12.8
		TBC	39	31.2
		Other	15	12.0
		<b>Total</b>	<b>125</b>	<b>100.0</b>
Prison		TBC	1	100.0
Unknown		Unknown	21	100.0
<b>GRAND TOTAL</b>			<b>3047</b>	<b>100.0</b>

## 7. Adult protection, care review and other referrals

Tables 10, 11 and 12 show the total number of eligible cases logged for adult protection, care reviews and 'other' cases respectively and whether they were open or closed.

*Table 10. Number of open / closed adult protection cases*

	Count	%
Open	268	39.4
Closed	413	60.6
<b>Total</b>	<b>681</b>	<b>100.0</b>

*Table 11. Number of open / closed care review cases*

	Count	%
Open	80	41.9
Closed	111	58.1
<b>Total</b>	<b>191</b>	<b>100.0</b>

*Table 12. Number of open / closed 'other' or unknown decision cases*

	Count	%
Open	445	76.1
Closed	140	23.9
<b>Total</b>	<b>585</b>	<b>100.0</b>

## 8. Reports

In 47% of all eligible IMCA cases input onto the data system a report was submitted. The breakdown for referral type is shown in table 13 below. The reasons given for not submitting a report are given in table 14.

*Table 13. Submission of report for each referral type*

Was a report submitted?	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
No	396	126	1407	17	301	481	2728	52.7
Yes	285	65	1640	11	374	76	2451	47.3
<b>Total</b>	<b>681</b>	<b>191</b>	<b>3047</b>	<b>28</b>	<b>675</b>	<b>557</b>	<b>5179</b>	<b>100</b>

Table 14. Reasons for not submitting a report

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Has Capacity	22	3	84		11	6	<b>126</b>	<b>4.62</b>
Befriended	7	14	151	1	28	13	<b>214</b>	<b>7.84</b>
Issue Resolved	40	4	33	1	11	5	<b>94</b>	<b>3.45</b>
Decision Not Required	29	5	61		30	2	<b>127</b>	<b>4.66</b>
Urgent Decision Needed	3		3		8	2	<b>16</b>	<b>0.59</b>
Death of Client	20	10	90	1	30	13	<b>164</b>	<b>6.01</b>
Client Moved	2		11				<b>13</b>	<b>0.48</b>
Other	34	16	77	2	22	13	<b>164</b>	<b>6.01</b>
None	239	74	897	12	161	427	<b>1810</b>	<b>66.35</b>
<b>Total</b>	<b>396</b>	<b>126</b>	<b>1407</b>	<b>17</b>	<b>301</b>	<b>481</b>	<b>2728</b>	<b>100</b>

NB. Cases included in table 14 were all logged as 'eligible', however the options of 'has capacity' or 'befriended' were included as a reason for not submitting a report because in some cases, although initially seen as eligible, after an IMCA has been involved it may come to light that the client has regained capacity or does is fact befriended.

## 9. Hours spent on each case

Table 15 contains the average number of hours spent on each aspect of each referral along with the average total number of hours spent on each case. Data includes all eligible, closed cases. On average the data indicates that adult protection cases take the longest to complete (about 10 hours) with care review cases taking the shortest amount of time (just over 6 hours). Changes in accommodation also take a relatively long time to complete (9.5 hours on average).

This data needs to be taken only as a rough guide as to how long cases are taking. This is due to the fact it is unclear how IMCA services are inputting the information into the system. For example, some organisations may be inputting a case which takes six and a half hours as '6.3' (as in 6 hours 30 minutes) rather than '6.5' or inputting a 45 minutes travelling as '0.45' instead of '0.75'. This would lead to the results being skewed and under-represented.

Table 15. Average number of hours spent on each aspect of each referral

	Total Hours With Client	Total Hours Consulting Others	Total Hours Obtaining Reviewing	Total Hours Report Writing	Total Hours Travelling	Total Hours Attending Decision Making Meetings	Total Hours Other	Total Hours On Each Case
Adult Protection	1.10	1.97	1.05	1.57	2.09	1.08	0.71	9.99
Care Review	0.61	1.12	0.56	0.98	1.49	0.60	0.42	6.17
Change in Accommodation	0.98	2.13	1.21	1.64	1.97	0.45	0.67	9.57
Other	0.67	2.59	0.80	1.63	1.55	0.24	0.97	8.97
Serious Medical Treatment	0.61	1.71	0.97	1.43	1.22	0.38	0.57	7.31
<b>All Referrals</b>	<b>0.88</b>	<b>1.92</b>	<b>1.08</b>	<b>1.50</b>	<b>1.77</b>	<b>0.51</b>	<b>0.63</b>	<b>8.76</b>

## 10. Evaluation of collaborative working and IMCA input

The following data shows how the IMCA organisations rated how well they worked with the Local Authority or NHS services involved in the case and visa versa. Data included here is for all eligible and closed cases.

Table 16. How well the LA / NHS worked with the IMCAs

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Very Well	192	61	879	6	236	36	1410	45.0
Well	144	40	717	5	167	52	1125	35.9
Not Well	37	6	204	2	44	9	302	9.6
Unknown	40	4	183		42	30	299	9.5
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100.0</b>

Table 17. How well IMCAs worked with the LA / NHS

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Very Well	241	68	1117	6	291	51	1774	56.6
Well	128	39	657	7	148	44	1023	32.6
Not Well	6		25		7	2	40	1.3
Unknown	38	4	184		43	30	299	9.5
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100.0</b>

The tables below include the data logged for eligible, closed cases for each decision type.

Table 18 shows that in 56.9% of the cases the IMCA was able to ascertain the wishes of the client and table 19 shows that in 52.6% of cases the IMCA felt the decision reflected the client's wishes. For 56.9% of the cases the IMCA felt that their input significantly affected the outcome of the decision (table 20). In 85.9% of cases the IMCA



did not challenge the decision. Nearly half of the IMCAs (45.7%) were very satisfied overall with the case and only 7.4% of IMCAs were not satisfied with the case overall.

**Table 18. Was the IMCA able to ascertain wishes?**

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Able to Ascertain Client's Wishes	256	75	1417	9	250	69	<b>2076</b>	<b>56.9</b>
Unable to Ascertain Client's Wishes	148	34	525	4	231	44	<b>986</b>	<b>40.7</b>
None	9	2	41		8	14	<b>74</b>	<b>2.4</b>
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100</b>

**Table 19. Did the decision reflect the client's wishes?**

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Decision Reflects Client's Wishes	214	57	1071	7	235	65	<b>1649</b>	<b>52.6</b>
Decision Does Not Reflect Client's Wishes	32	11	200	1	22	6	<b>272</b>	<b>8.7</b>
Decision Reflects Client's Wishes Partly/Can't Tell	158	41	671	5	224	42	<b>1141</b>	<b>36.4</b>
None	9	2	41		8	14	<b>74</b>	<b>2.4</b>
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100</b>

**Table 20. Was the outcome significantly affected by the IMCA involvement?**

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Outcome Significantly Affected By IMCA Involvement	260	55	1149	7	247	66	<b>1784</b>	<b>56.9</b>
Outcome Not Significantly Affected By IMCA Involvement	144	54	793	6	233	47	<b>1277</b>	<b>40.7</b>
None	9	2	41		9	14	<b>75</b>	<b>2.4</b>
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100</b>

**Table 21. Did the IMCA challenge the decision? (closed cases only)**

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
IMCA Challenged Decision	41	2	243		57	26	<b>369</b>	<b>11.8</b>
IMCA Didn't Challenged Decision	363	107	1699	13	424	87	<b>2693</b>	<b>85.9</b>
None	9	2	41		8	14	<b>74</b>	<b>2.4</b>
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100</b>

**Table 22. Overall satisfaction with the case (closed cases only)**

	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
Very Satisfied	197	60	892	7	232	44	<b>1432</b>	<b>45.7</b>
Quite Satisfied	132	38	680	4	161	38	<b>1053</b>	<b>33.6</b>
Not Satisfied	29	3	148	2	39	10	<b>231</b>	<b>7.4</b>
Unknown	55	10	263		57	35	<b>420</b>	<b>13.4</b>
<b>Total</b>	<b>413</b>	<b>111</b>	<b>1983</b>	<b>13</b>	<b>489</b>	<b>127</b>	<b>3136</b>	<b>100</b>

*Table 23 All Authorities:  
IMCA Referrals April 2007 - March 2008*

Rank	Authority	Eligible	Not Eligible	Total
1	NORFOLK	168	20	188
2	WEST SUSSEX	163	30	193
3	SUFFOLK	133	47	180
4	CORNWALL	128	44	172
5	MANCHESTER	116	64	180
6	SURREY	114	5	119
7	LEEDS	113	3	116
8	LANCASHIRE	110	160	270
9	ESSEX	104	12	116
10	KENT	93	30	123
11	GLOUCESTERSHIRE	91	8	99
12	CAMBRIDGESHIRE	87	78	165
13	CESHIRE	79	35	114
14	BIRMINGHAM	75	51	126
15	STAFFORDSHIRE	75	32	107
16	HERTFORDSHIRE	73	13	86
17	BRISTOL UA	73	19	92
18	CUMBRIA	72	54	126
19	NOTTINGHAMSHIRE	66	1	67
20	HAMPSHIRE	59	129	188
21	PLYMOUTH UA	59	10	69
22	DORSET	58	11	69
23	LIVERPOOL	57	46	103
24	SUTTON	57	8	65
25	CAMDEN	55	14	69
26	EAST SUSSEX	55	15	70
27	LAMBETH	54	22	76
28	WESTMINSTER	54	15	69
29	WALTHAM FOREST	51	4	55
30	BARNET	50		50
31	SOMERSET	49	36	85
32	CROYDON	48	25	73
33	TOWER HAMLETS	47	14	61
34	BRIGHTON & HOVE UA	46	15	61
35	NORTH YORKSHIRE	45	9	54
36	ENFIELD	44	1	45
37	WIGAN	43	15	58
38	WANDSWORTH	42	18	60
39	BOURNEMOUTH UA	42	17	59

40	SEFTON	41	23	64
41	ISLINGTON	41	12	53
42	WIRRAL	40	2	42
43	DERBYSHIRE	39	36	75
44	LEICESTER UA	39	8	47
45	YORK UA	38	4	42
46	SOUTHWARK	37	6	43
47	BATH & NORTH EAST SOMERSET UA	37	11	48
48	DEVON	36	109	145
49	TORBAY UA	36	39	75
50	LINCOLNSHIRE	35	15	50
51	WILTSHIRE	35	23	58
52	TAMESIDE	33	21	54
53	NORTHAMPTONSHIRE	33	35	68
54	DURHAM	32	9	41
55	SHEFFIELD	32	10	42
56	KIRKLEES	32	1	33
57	WARWICKSHIRE	32	8	40
58	WORCESTERSHIRE	32	13	45
59	OXFORDSHIRE	32	4	36
60	DONCASTER	31	5	36
61	SALFORD	31	2	33
62	NOTTINGHAM UA	31	1	32
63	LEWISHAM	31	7	38
64	STOKE-ON-TRENT UA	30	25	55
65	BUCKINGHAMSHIRE	30	10	40
66	KINGSTON UPON THAMES	30		30
67	REDBRIDGE	30	12	42
68	BARNSELY	29	3	32
69	BROMLEY	29	5	34
70	POOLE UA	28	7	35
71	WAKEFIELD	27	3	30
72	MILTON KEYNES UA	27	3	30
73	NEWCASTLE UPON TYNE	26	6	32
74	LEICESTERSHIRE	26	2	28
75	KENSINGTON & CHELSEA	26	12	38
76	NEWHAM	26	9	35
77	BLACKPOOL UA	25	22	47
78	KINGSTON UPON HULL UA	24	3	27
79	ST HELENS	24	1	25
80	DUDLEY	24	5	29

81	PORTSMOUTH UA	24	12	36
82	OLDHAM	23	6	29
83	BLACKBURN WITH DARWEN UA	23	26	49
84	PETERBOROUGH UA	23	27	50
85	BOLTON	22	3	25
86	STOCKPORT	22	10	32
87	BEDFORDSHIRE	22	9	31
88	READING UA	22	9	31
89	SOUTHAMPTON UA	22	21	43
90	NORTH SOMERSET UA	22	29	51
91	EAST RIDING OF YORKSHIRE UA	21	11	32
92	SUNDERLAND	20	11	31
93	CALDERDALE	19	8	27
94	ROCHDALE	19	6	25
95	WARRINGTON UA	19	5	24
96	HACKNEY	19	1	20
97	RICHMOND UPON THAMES	19	2	21
98	COVENTRY	18		18
99	DERBY UA	18	26	44
100	SOUTHEND UA	18	3	21
101	GREENWICH	18	4	22
102	BARKING & DAGENHAM	18	25	43
103	HOUNSLOW	18	4	22
104	SOUTH GLOUCESTERSHIRE UA	18	29	47
105	DARLINGTON UA	17	1	18
106	NORTH LINCOLNSHIRE UA	17	2	19
107	MIDDLESBROUGH UA	16	3	19
108	BRADFORD	16	14	30
109	SANDWELL	16	19	35
110	NORTH TYNESIDE	15	2	17
111	HARTLEPOOL UA	15	1	16
112	SLOUGH UA	15	1	16
113	HARINGEY	15	4	19
114	CARDIFF UA	14	3	17
115	NORTHUMBERLAND	14	3	17
116	KNOWSLEY	14	2	16
117	BRENT	14	5	19
118	MEDWAY TOWNS UA	14	3	17
119	SOUTH TYNESIDE	13	9	22

120	BURY	13	8	21
121	WOLVERHAMPTON	13	12	25
122	GATESHEAD	12	3	15
123	HEREFORDSHIRE UA	12	4	16
124	TELFORD & WREKIN UA	12	3	15
125	HAMMERSMITH & FULHAM	12	4	16
126	MERTON	12	3	15
127	HAVERING	11	29	40
128	HALTON UA	10	1	11
129	WINDSOR & MAIDENHEAD UA	10	1	11
130	EALING	10	4	14
131	ISLE OF WIGHT UA	10	11	21
132	REDCAR & CLEVELAND UA	9	3	12
133	ROTHERHAM	9	4	13
134	SOLIHULL	9		9
135	SHROPSHIRE	9	4	13
136	BRACKNELL FOREST UA	9		9
137	STOCKTON ON TEES UA	7	1	8
138	TRAFFORD	7	3	10
139	HARROW	7	1	8
140	SWINDON UA	7	9	16
141	HILLINGDON	6	4	10
142	BEXLEY	5	3	8
143	NORTH EAST LINCOLNSHIRE UA	4	3	7
144	THURROCK UA	4	14	18
145	WALSALL	3	6	9
146	LUTON UA	3	1	4
147	WOKINGHAM UA	1	0	1
148	RUTLAND UA	0	0	0
149	ISLES OF SCILLY	0	0	0
150	CITY OF LONDON	0	0	0
	<b>Total</b>	<b>5273</b>	<b>2210</b>	<b>7483</b>