The Fourth Year of the Independent Mental Capacity Advocacy (IMCA) Service: 2010 /2011

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Executive Summary

Introduction

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service to safeguard people without the capacity to make certain important decisions. The Act also introduced a legal duty on NHS bodies and local authorities to refer eligible people to the IMCA service. The IMCA service started on 1st April 2007 and this is the report on its fourth year's work (1st April 2010 – 31st March 2011).

The role of the IMCA is to represent and support people at times when critical decisions are being made about their health or social care. They are mainly involved when the person lacks capacity to make these decisions themselves and they do not have family or friends who can represent them.

The Deprivation of Liberty Safeguards (DOLS) amended the Mental Capacity Act and were implemented on the 1st April 2009. IMCAs have an important role to support people who may be subject to these safeguards. Data on the DOLS is published by the NHS Information Centre. This report draws also from the second annual report on DOLS to examine how frequently IMCAs are undertaking these roles.

Data about the IMCA service is added by IMCA providers to a national database maintained by the Health and Social Care Information Centre. This report presents the information recorded on this database collected on the19th September 2011.

The results

During the fourth year there were 10,680 eligible instructions for the IMCA service in England. This is a 15.4% increase in the support and representation provided by IMCAs compared to the previous year.

The breakdown of instructions by decision type is shown below together with the percentage increase compared to year 3.

- Accommodation 4,530 (Increase of 8%)
- Serious medical treatment 1630 (Increase of 22%)
- Adult protection 1,548 (Increase of 13%)
- Care reviews 751 (Increase of 20%)
- Deprivation of Liberty Safeguards 1,669 (Increase of 33%)

The type of eligible instruction was unrecorded in 602 cases.

The Department of Health is pleased that there has been a continuing increase in instructions to the IMCA service in all areas as more people are now receiving the support and representation they are entitled to. However there are still wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population

differences. It is likely that in some areas the duties under the MCA are still not well embedded. The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector.

Action for Advocacy has been working with health trusts and IMCA providers to help address the low numbers of instructions for serious medical treatment decisions. The relatively high rate of increase in this area may partly reflect the success of this work.

The Mental Capacity Act Code of Practice states that local authorities and NHS trusts should have policies on when IMCAs should be instructed to represent people who are the focus of safeguarding adults' procedures and care reviews. Model policies have been developed by ADASS and SCIE. Local policies are needed in both health and social care – including when to instruct IMCAs for continuing NHS healthcare reviews.

Care Reviews

The number of instructions for care reviews continues to be low in comparison to accommodation decisions (16.6%). This raises the following questions:

- Are care reviews being consistently undertaken after moves?
- Where an IMCA has been involved in the decision to move a person, why are they not involved in the subsequent reviews?

Department of Health guidance states that it is good practice for local authorities to undertake a review within three months of a person moving to new accommodation or where there have been other major changes to the support plan. Otherwise, reviews should take place at least annually. The guidance, contained *in Prioritising need in the context of Putting People First (DH 2010a*) also says that 'adults lacking capacity are likely to need more frequent monitoring arrangements than other service users' (Section 146).

For people receiving continuing healthcare, the NHS continuing healthcare practice guide (DH 2010b) recommends that reviews should similarly take place by the relevant PCT within three months of the decision to provide continuing care, and then at least annually.

DOLS

Eligible Deprivation of Liberty Safeguards (DOLS) instructions showed the greatest level of increase from the previous year (33%). Over the same period DOLS applications for standard authorisations, and authorisations granted increased by 25% and 50% respectively[1].

Quality and Guidance

The Department of Health supported a number of initiatives to promote the quality of IMCA services during this period. While the IMCA services are all commissioned locally and are accountable locally – together they are a national service that is statutory under the Mental Capacity Act. Quality remains important both locally and nationally.

[1] Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11. The Health and Social Care Information Centre.

This Department has supported:

- The development by Action for Advocacy of an IMCA specific review for the Quality Performance Mark for advocacy services

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

- Good practice guides published by ADASS and SCIE on:

  Accommodation decisions and care reviews

  http://www.scie.org.uk/publications/guides/guide39/about.asp

  Access to the Court of Protection

  http://www.scie.org.uk/publications/guides/guide42/

  The IMCA roles within the Deprivation of Liberty Safeguards

  http://www.scie.org.uk/publications/guides/guide41/

  Commissioning IMCA services (revision)

  http://www.scie.org.uk/publications/guides/guide31/

- Good practice guide on serious medical treatment by Action for Advocacy

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

- Research into the difference IMCAs makes to the lives of individuals and the knowledge and practice of health and social care workers; commissioned by SCIE from the Norah Fry Research Centre at the University of Bristol.

  http://www.scie.org.uk/publications/imca/files/IMCAreportFINALv35.pdf

The previous IMCA annual report drew attention to the development of a national advocacy qualification with two specialist modules for IMCAs. Information collected from eight of the qualification providers at the end of March 2011 showed good progress in uptake. Over 225 IMCA had at that time been registered for the qualification. Of these over 75 IMCA had successfully completed the first IMCA module and 35 the Deprivation of Liberty Safeguards module.

IMCAs continued to be involved in cases taken to the Court of Protection. A significant published Court judgement was positive about the work of the IMCAs in the case (the Neary case).

Main Report

1. The origin of the IMCA service

The Mental Capacity Act 2005 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 provide a safeguard to particularly vulnerable people who may lack the capacity to make critical decisions.

The duty to instruct the IMCA service applies to specific decisions for people who lack capacity to make those decisions. The decisions identified in the original Act were: serious medical treatment and a move to, or a change in, long term accommodation. Regulations then introduced two further decisions where an IMCA service may be instructed: adult protection and care reviews. 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 decision making. IMCAs have been providing support to people in all these areas since April 2007.

2. The Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 was amended by the Mental Health Act 2007. This added new provisions to the Act: the Deprivation of Liberty Safeguards. The safeguards focus on some of the most vulnerable circumstances that people in our society can find themselves in: where for their own safety and in their best interests people need to be accommodated under care and treatment regimes that have the effect of depriving them of their liberty, but where they lack the capacity to consent to the regime.

The Deprivation of Liberty Safeguards (DOLS) extended the IMCA role to act as a key safeguard to people who may be subject to this legislation. The Department of Health supported further training of IMCAs so that they were be knowledgeable about their rights and responsibilities. A specific module of the qualification in independent advocacy provided by City and Guilds equips IMCAs for this role.

There are three distinct IMCA roles in the Deprivation of Liberty Safeguards. These are referred to by the Sections in the amended Mental Capacity Act where they are described.

- Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.

- Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.

- Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

These roles have distinct powers and responsibilities. Collectively in the report they are referred to as the DOLS IMCA roles.

3. The source of the data

Since the IMCA service began in April 2007 IMCA providers have been recording details about each case on a national database maintained by the Health and Social Care Information Centre. This report provides information about recorded IMCA instructions which were made on or between the 1st April 2010 and the 31st March 2011.

The database records data for England and Wales. This report only includes the data for England.

IMCA providers may record both eligible and ineligible IMCA instructions on the database. An instruction may be ineligible if the criteria set out in the Mental Capacity Act 2005 are not met. For example:

- A formal instruction was not received from either a local authority or health trust.
- A family member or friend is identified who can be consulted and who can represent their interests.
- The person is found to have capacity to make the decision for themselves
- The decision is not one where there is a duty or power to instruct an IMCA

The figures presented only include those instructions which the IMCA providers marked as eligible.

The data presented here was collected on the 19th September 2011. Comparisons are made in this report with previous years of the IMCA service. The data was similarly drawn on the 19th September 2010. There is some variance with the figures contained in the earlier annual IMCA reports due to data being amended or added by IMCA providers. For example the third annual IMCA report recorded a total of 9173 eligible instructions for the third year of the IMCA service. On the 19th September 2011 this had increased to 9,296 because of late reporting by some IMCA providers.

4. Number of eligible IMCA instructions

There were 10,730 eligible IMCA instructions during year 4. This represents an increase of 15.4% on year 3. Table 1 shows the eligible instructions for the first four years by reason for IMCA instruction. The numbers for year 4 are shown. The type of eligible instruction was unrecorded in 602 cases in this year.

This table shows year on year increases in all areas of IMCA work nationally. Accommodation decisions continue to dominate the work of IMCAs making up 42.2% of all eligible instructions in year 4. The number of DOLS instructions in the fourth year (1,669) is similar to that of serious medical treatment (SMT) and adult protection instructions. This was also the case in year 3 (1255, 1335 & 1369 respectively)

Table 1 Eligible IMCA instructions

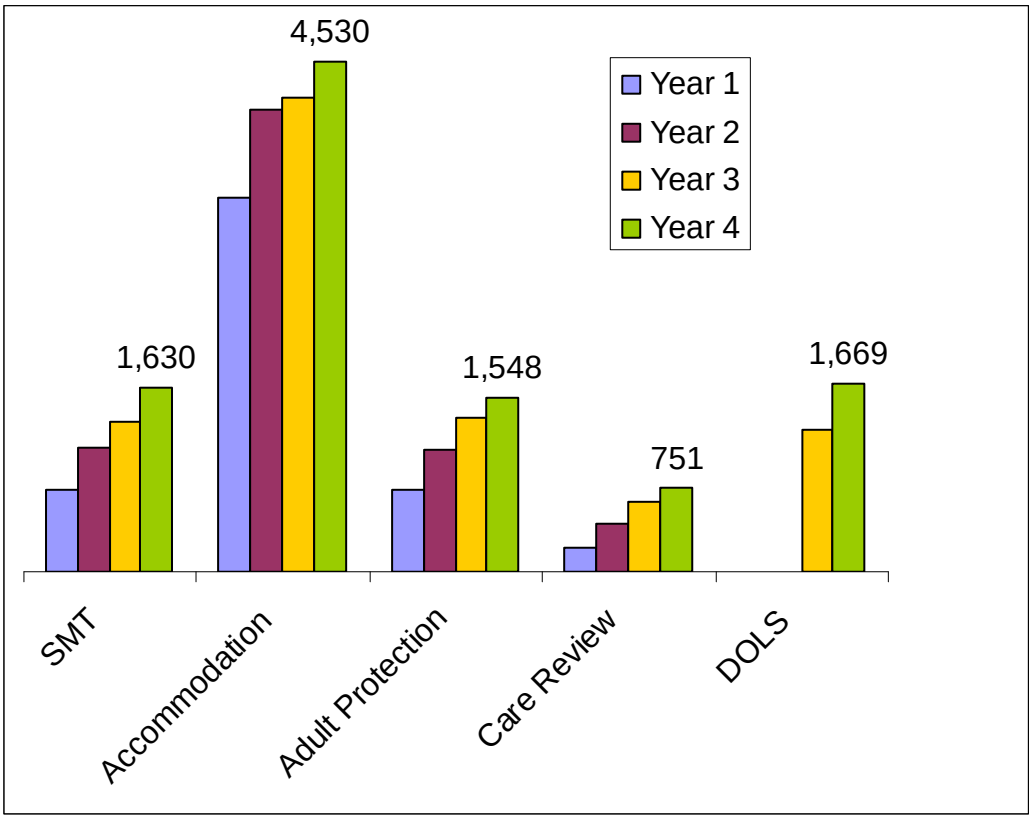
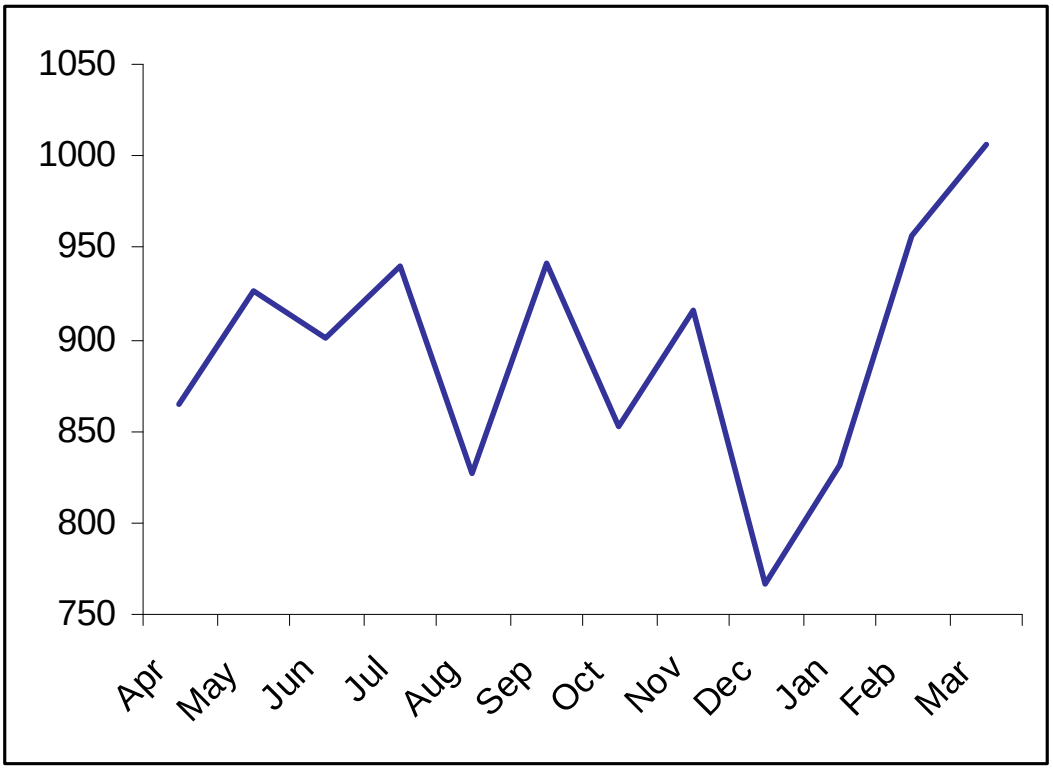


Table 2 shows the total numbers of eligible instructions during 2010/11 by months.

There are two clear dips in the rate of instructions. These are around the months of August and December. This may reflect holiday patterns in local authorities and NHS trusts affecting levels of instructions.

Table 2 Total number of eligible instructions during 2010/11 by month



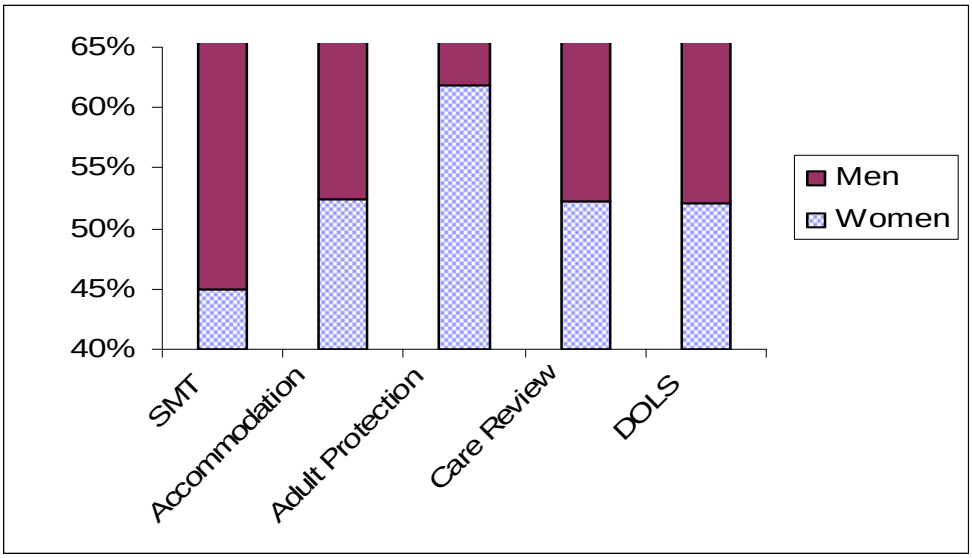
5. Who benefits from the IMCA service

Fifty three per cent of people receiving the IMCA service in year 4 were women (in just over one per cent the gender is unknown). This continues the pattern seen in the first three years of the ratio of women slightly exceeding the percentage of women in the adult population in England which currently stands at 51[2]. This variation may be partly explained by the age profile of people receiving the IMCA service (see below).

Table 3 shows the gender breakdown by reason for instruction where known. It reveals two significant variations in gender. The first being the relatively high proportion of women represented for adult protection issues - 62%, and the relatively low proportion of women represented for serious medical treatment decisions - 45%. This pattern was also identified in the previous report.

[2] Mid -2009 Population Estimates England, Office for National Statistics

Table 3 Gender by type of eligible instruction



The age profile of people instructed to the IMCA service has remained largely consistent. Table 4, for example shows the percentage of instructions by age group for the last two years where the age was recorded.

Table 4: Instructions by age category for year 3 and 4

Age range	Year 3 percentage of all instructions	Year 4 percentage of all instructions
16 - 17	0.1%	0.3%
18 - 30	6.1%	5.2%
31 - 45	8.4%	7.4%
46 - 65	24.2%	24.8%
66 - 79	26.3%	25.6%
80 +	34.8%	36.6%

IMCAs can be provided to people aged 16 and over. In practice there have been very few instructions for people aged 16 or 17. In year 4 there were just 27 instructions for people under the age of 18. They included 2 for serious medical treatment, 16 accommodation, 3 adult protection, 3 care review and 1 DOLS instructions. These instructions are not included in the analysis of age by decision type shown in table 5.

There has been an increase in the number of these young people accessing the service compared to the previous year (where just 10 were recorded). This suggests there may be a growing recognition in young people's services of when IMCAs must or may be involved.

Table 5 shows some clear age variations in the reasons for instructions. The age profile for serious medical treatment decisions stands out as being significantly different. For example, people 80 and over, make up only 19% of serious medical treatment instructions compared to 40% of all other eligible instructions. Whilst those people between the ages of 46 and 65 make up 41% of serious medical treatment instructions compared to 26% of all other eligible instructions.

This pattern is found in the previous year's data and continues to raise concerns about the possible underrepresentation of older people who lack capacity in the number of instructions for serious medical treatment decisions.

Table 5 Age profile by reason for instruction

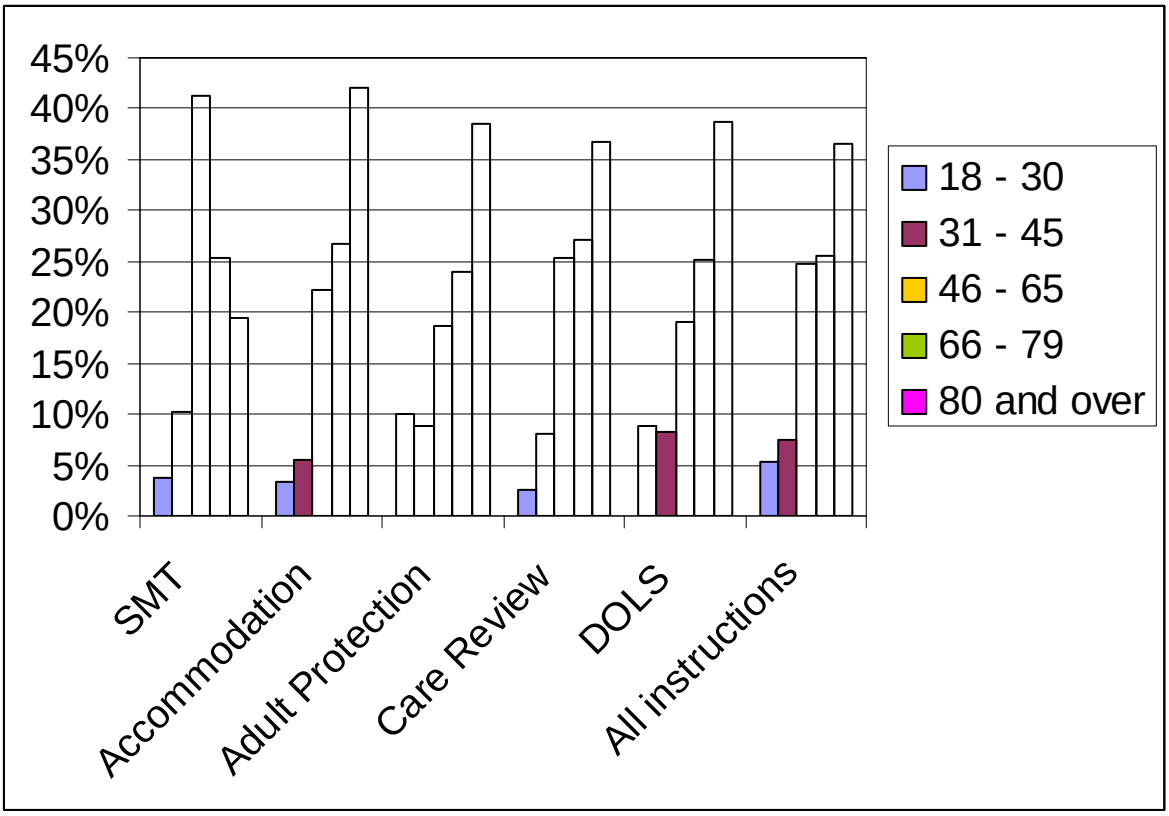


Table 6 shows the ethnicity of the people instructed where known. This is broadly in line with the population of England. Because the majority of people who receive the service are 66 or over, a comparison for the number of men over 65 and women over 60 is given[3].

[3] Source Current Estimates - Population Estimates by Ethnic Group Mid-2007 (experimental), Office of National Statistics.

Table 6: Ethnicity of people receiving the IMCA service

Ethnic group	IMCA instructions (n)	Percentage IMCA instructions where ethnicity recorded	England population all ages (%)	England men 65+ women 60+ (%)
White	9548	93%	91%	96%
Asian or Asian British	228	2%	5%	2%
Black or Black British	319	3%	2%	1%
Mixed	76	0.7%	1%	0.3%
Chinese, including British Chinese	22	0.2%	0.4%	0.2%
Other	40	0.4%	0.4%	0.2%

6. Why people may lack capacity to make decisions

The first stage of the mental capacity assessment is to identify if a person has an impairment of the function of the brain. Table 7 shows the reasons the different mental impairments recorded.

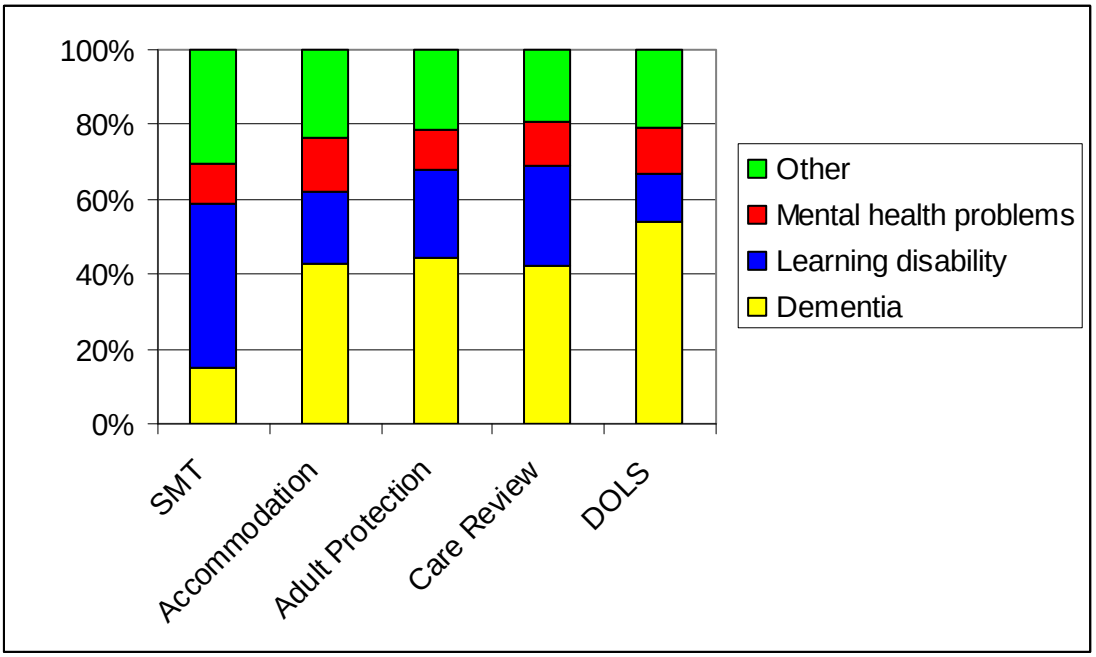
The most common impairments for people receiving the IMCA service in year 3 were dementia (38%), learning disabilities (23%) and mental health problems other than dementia (12%). These are very similar to the figures for year 3 (38 %, 23% & 12% respectively).

Table 7: Mental impairment

	Year 4 (n)	Percentage of eligible instructions
Acquired brain injury	535	5.0%
Autism spectrum disorder	198	1.8%
Cognitive impairment	878	8.2%
Combination	322	3.0%
Dementia	4,092	38.1%
Learning disability	2,421	22.6%
Mental health problems	1,284	12.0%
Serious physical illness	427	4.0%
Unconscious	51	0.5%
Other	245	2.3%
Not Specified	277	2.6%
Total	10,730	100.0%

Table 8 shows the mental impairment by decision type where both are known. The impairments other than dementia, learning disabilities and mental health problems are grouped together under ‘other’. The most distinct difference is the proportions of the different impairments for serious medical treatment. There are a relatively low proportion of people with dementia who received the support of an IMCA for a serious medical treatment decision (14.8%), reflecting in part the relatively low number of people over 80 identified above who receive this service. Also significant are the high proportion of people with learning disabilities who are supported by IMCAs for serious medical treatment decisions (43.8%).

Table 8: Impairment and type of instruction



7. Where were people staying when the IMCA was instructed

Table 9 shows where the person was staying at the time of the IMCA instruction, where this was recorded (10,011 of the 10,720 cases). The category 'other' includes four people who were in prison. In two cases this was for serious medical treatment decisions. In one it was for representation about where they should live after they were released (the other instruction is not recorded).

The vast majority of people were staying in either a hospital (36%) or nursing or residential care home (45%) when an IMCA was instructed. Only 16% of people were living in their own home or supported living.

Table 9: Where the person was staying at time of instruction

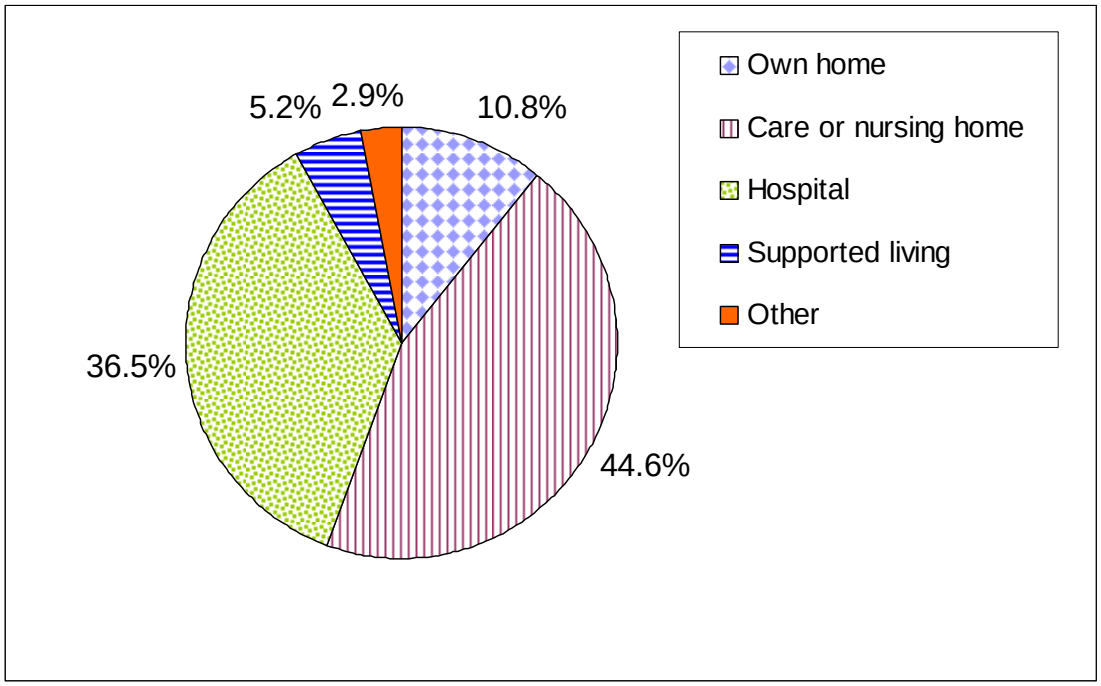
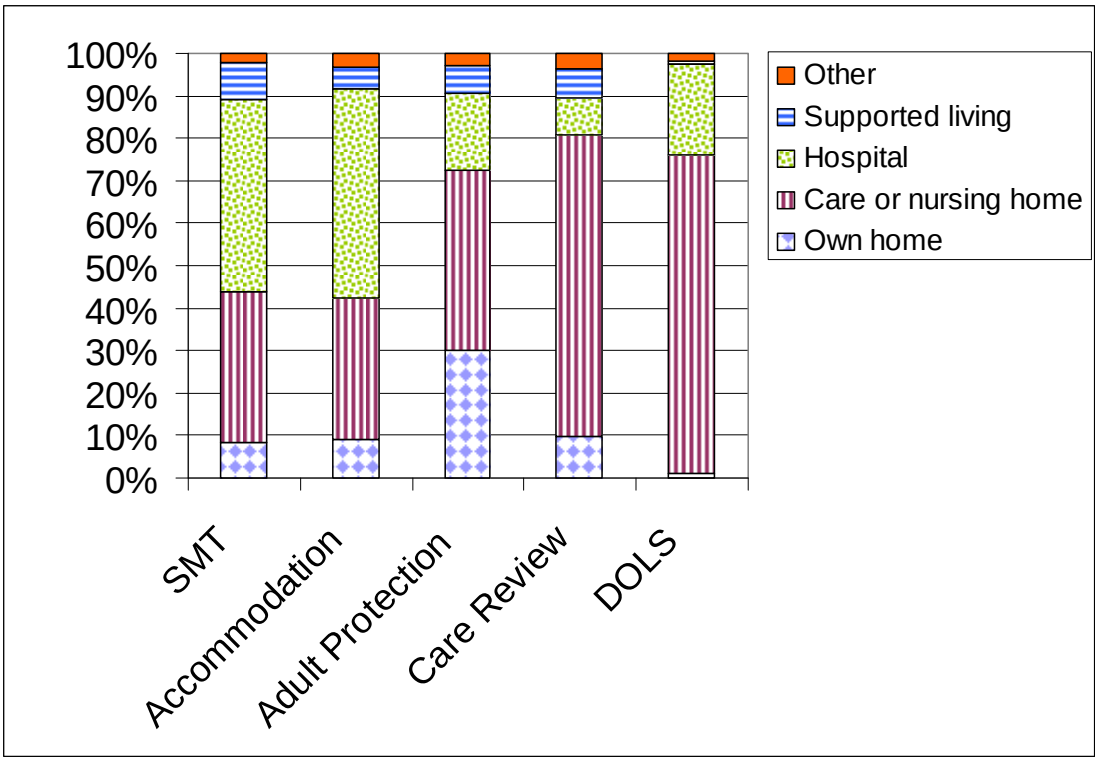


Table 10 examines where people were staying at time of instruction compared to the reason for instruction where both are recorded.

Of note are the relatively high levels of instructions in relation to safeguarding, for people living in their own home, particularly compared to the number for people staying in hospital.

Table 10: Where people were staying for different instructions



8. Serious medical treatment decisions

There is a duty to instruct IMCA when a serious medical treatment decision needs to be made in the best interests of someone lacking capacity to make that decision, where the person does not have anyone appropriate to consult.

Table 11 records the range and number of medical decisions where people received the support of an IMCA. The most common decisions relate to medical investigations (16%), dental work (13%), whether resuscitation should be attempted (12%) and cancer treatment (8%). This pattern has been seen in previous years.

One difference is the absence of any IMCA instructions for pregnancy terminations during year 4. Over the previous three years there has been a total of 9 instructions to represent women where termination was being considered.

Table 11: Serious medical treatment decisions

Serious medical treatment	n = 1630	%
Medical investigations	268	16.4%
Dental work	216	13.3%
Do not attempt to resuscitate	191	11.7%
Cancer treatment	139	8.5%
Major surgery	56	3.4%
Artificial nutrition or hydration	46	2.8%
Hip or leg operation	41	2.5%
Affecting hearing or sight	35	2.1%
Major amputation	16	1.0%
ECT	6	0.4%
Other or not specified	616	37.8%

IMCAs have a right to request a second medical opinion in relation to the treatment decision. This right was exercised in 154 cases (9 % of SMT decisions) and led to second medical opinions being provided in 141 (91% cases where requested). The reasons why a second medical opinion was not obtained when requested are not recorded. It could include the person dying.

9. The outcomes of the accommodation decisions

Table 10 above showed where the person was staying at the time an IMCA was instructed where recorded. Almost a half of the accommodation decisions were where a person should move to after a stay in hospital (49.5%). Other accommodation decisions involved people initially living in care or nursing homes (33%), their own home (9%) or some form of supported living (5%). For the remaining 3 % of accommodation decisions, the original accommodation was recorded as ‘other’. This includes one person in prison who moved to a care home.

Table 12 compares where the person was staying when the IMCA with instructed with the outcome of the accommodation decision where this is known. The outcome is not recorded in 34% of cases. The person dying before a decision was made or where the decision is yet to be made in part explains why so much data here is missing. The failure of some IMCA providers to enter the outcome will also be a factor.

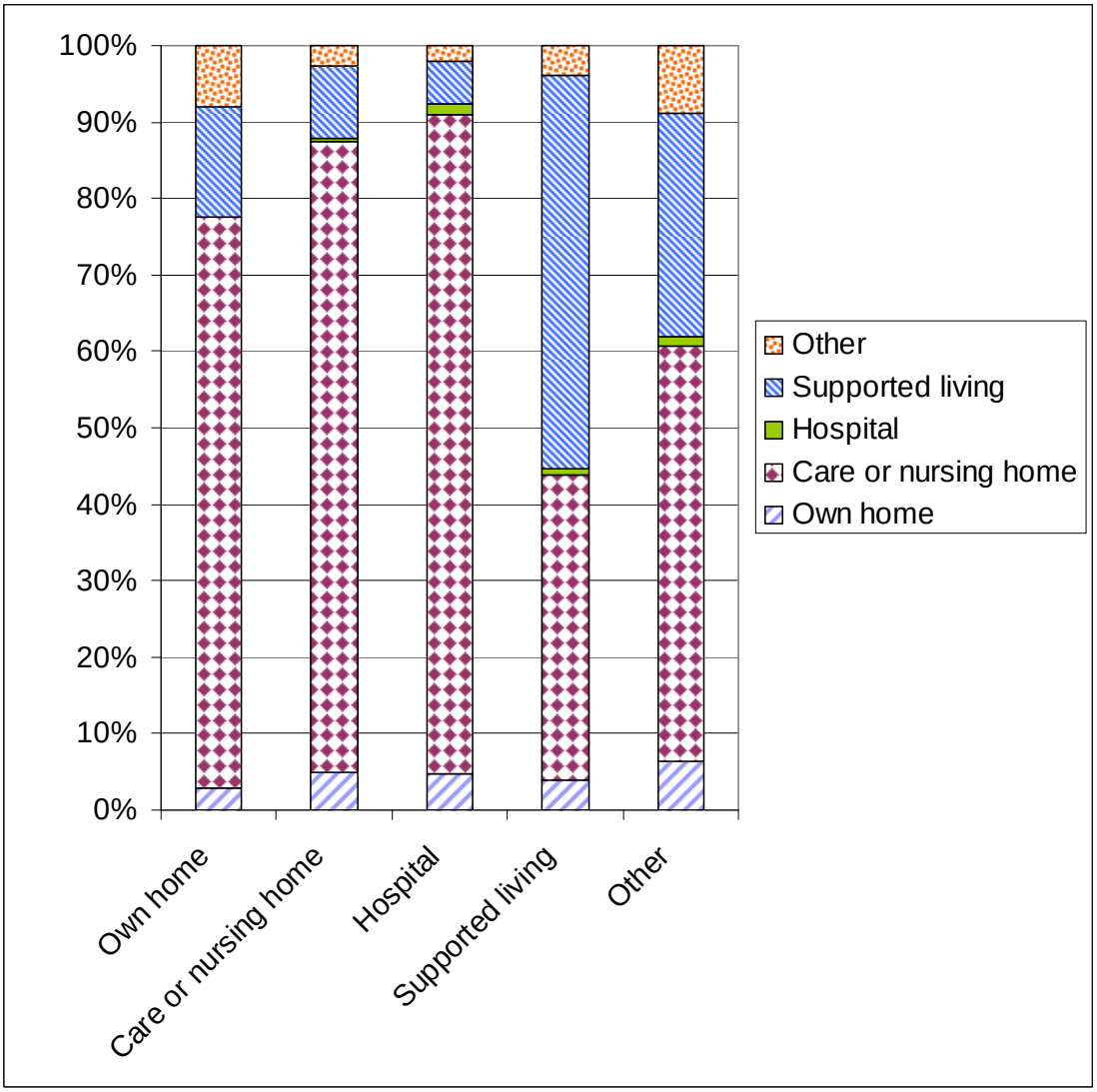
Where a person is shown to stay in the same type of accommodation type they may or may not have moved. For example a decision to move from supported living to supported living could either involve staying in the same setting or moving to an alternative supported living arrangement.

The lack of a clear distinction between ‘own home’ and ‘supported living’ also makes some of these results difficult to interpret. For example, if someone is living in their own home and the outcome of the accommodation decision is to provide a package of support to allow them to continue to live there it is not clear whether the IMCA provider should record the outcome as ‘own home’ or ‘supported living’.

Where a person is shown to stay in the same type of accommodation they may still have moved. For example, from one care home to another.

In 2890 cases information is available about both where a person was at time of instruction and the outcome of accommodation decision. In 81% of cases the decision was for the person to live in a care home or hospital. People staying in hospital were the most likely to move to a care home (86%).

Table 12: Outcomes of accommodation decisions



IMCAs may have an impact on the type of accommodation but also the choice or accommodation. For example, how well a particular care home will represent the person's best interests. IMCAs may also have an impact on the support the person receives in the care home. This can happen by IMCAs providing information to the care home provider about the person's history, needs and wishes. IMCA reports are an important part of a person's 'life story'information.

As was reported in year 3, planned stays in hospital continue to account for less than 1% of accommodation decisions. IMCAs must be instructed for non emergency admissions where the stay in hospital is likely to be 28 days or longer. The Code of Practice also expects IMCAs to be instructed by NHS bodies as soon as they realise that a stay in hospital may exceed 28 days (10.55).

10. The Deprivation of Liberty Safeguards

This report provides data on the second year of the IMCA roles in the Deprivation of Liberty Safeguards. The three roles are:

- Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.
- Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.
- Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

Table 13 Breakdown of IMCA DOLS instructions

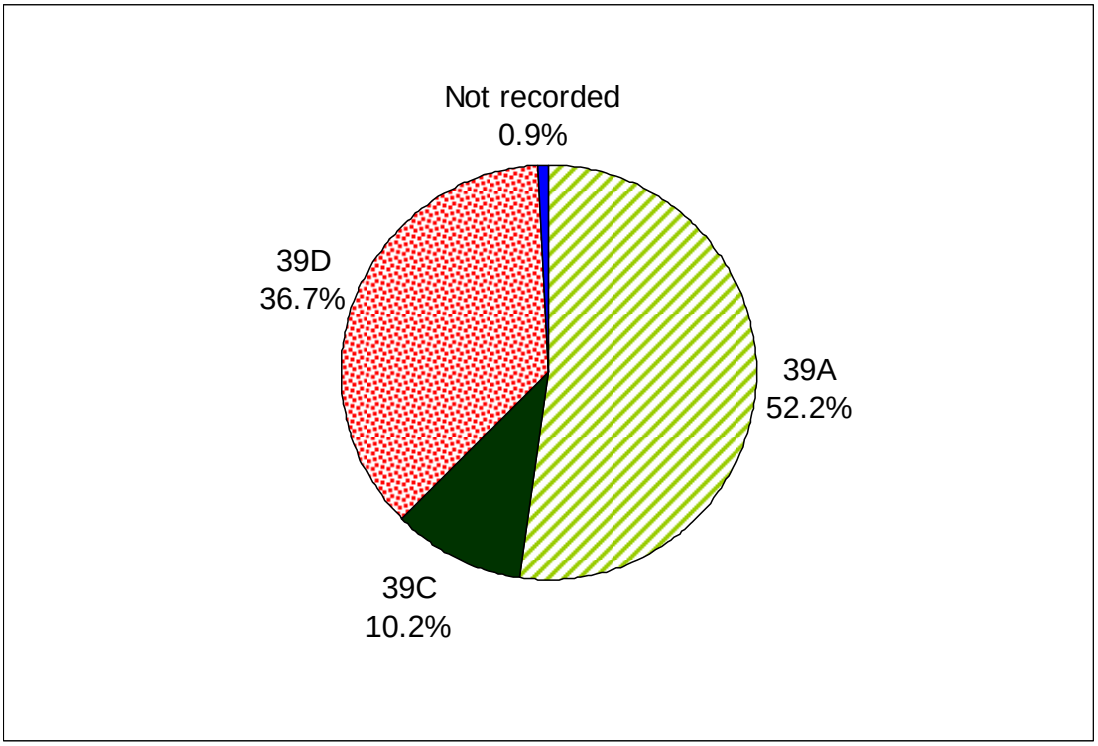


Table 13 shows the breakdown of the 1,669 DOLS instructions in year 4. It shows that just over half (52%) of the DOLS IMCA instructions were to support and represent people who were being assessed as to whether they are being, or need to be deprived of their liberty (the section 39A role). The two other IMCA roles provide safeguards for people who are subject to a standard authorisation. 39C and 39D instructions accounted for 10% and 37% of total DOLS instructions.

The breakdown of DOLS instructions is significantly different to the previous year where 39A, 39C and 39D accounted for 71%, 13% and 14% respectively of the 1225 DOLS instructions

(1.7% unknown). To help understand these changes it is helpful to relate this to the statistics published for DOLS activity across both years.[4]

Section 39A IMCAs must be provided for those people who are either:

- being assessed as a result of an application for a standard authorisation, or
- being assessed for a potential unlawful deprivation of liberty (also referred to as third party requests)

where the person does not have anyone independent (e.g. a family member or friend) who can support and represent them during the assessment process.

Table 14 Section 39A instructions as a proportion of assessments

	Year 3	Year 4
Applications for standard authorisations	7,157	8,982
Third party requests	147	99
Total assessments when a 39A IMCA could be instructed	7,304	9,081
Section 39A instructions	897	871
% of assessment where an IMCA was provided	12.3%	9.6%

Table 14 shows that the rate of section 39A instructions related to either applications for standard authorisations or third party requests has decreased from 12.3% to 9.6%. This reduction may be explained by the increasing numbers of applications for standard authorisations for people where there is one already in place over this period. This could, for example, allow deprivation of liberty to continue beyond the duration of an existing authorisation. Even if a 39A IMCA was instructed for the first authorisation it is unlikely that a 39A IMCA would be required for subsequent authorisations as it is expected that the person would then be represented in the assessment process by their relevant person's representative (see MCA 2005, Section 39A(6)).

The outcome in year 4 of the application for a standard authorisation where a section 39A IMCA was instructed is unknown in 22% of cases (a similar proportion to year 3: 22.3%). Where the outcome is known, authorisations were granted in 60.2% of cases (again very

[4] Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11. The Health and Social Care Information Centre.

Table 14 combines data from A) Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11 – published by he Health and Social Care Information Centre (the first three rows) and B) The IMCA database (the fourth row).

similar to year 3: 61.7%). This compares to an overall rate of authorisations being granted in 55.1% of cases (up from 46.1% in year 3). This reinforces the suggestion in the third year report that the involvement of a section 39A IMCA may increase the probability of an authorisation being granted. This effect may be more significant than these figures suggest. This is because 39A IMCAs are very unlikely to be involved in applications for authorisations where a standard authorisation is already in place where the probability of these being granted may be assumed to be higher than new applications.

Both 39C and 39D IMCAs are only available to people who are subject to an authorisation. Therefore it is helpful to compare the number of these instructions with the number of standard authorisations at the time. Table 15 plots the number of these instructions each quarter alongside the total number of people subject to an authorisation at the end of each quarter.

Section 39D instructions are shown in table 15 to have increased significantly over the two years.

This is both in absolute numbers and as a proportion of people who are subject to a standard authorisation. The high point was July – September 2011 where the 176 Section 39D instructions represented 12.4% of the 1418 standard authorisation that were in place at the end of this quarter. The low point was the first quarter of the implementation of the DOLS when the 20 Section 39D instructions represented just 3.7% of the 536 standard authorisation that were in place at the end of June 2010.

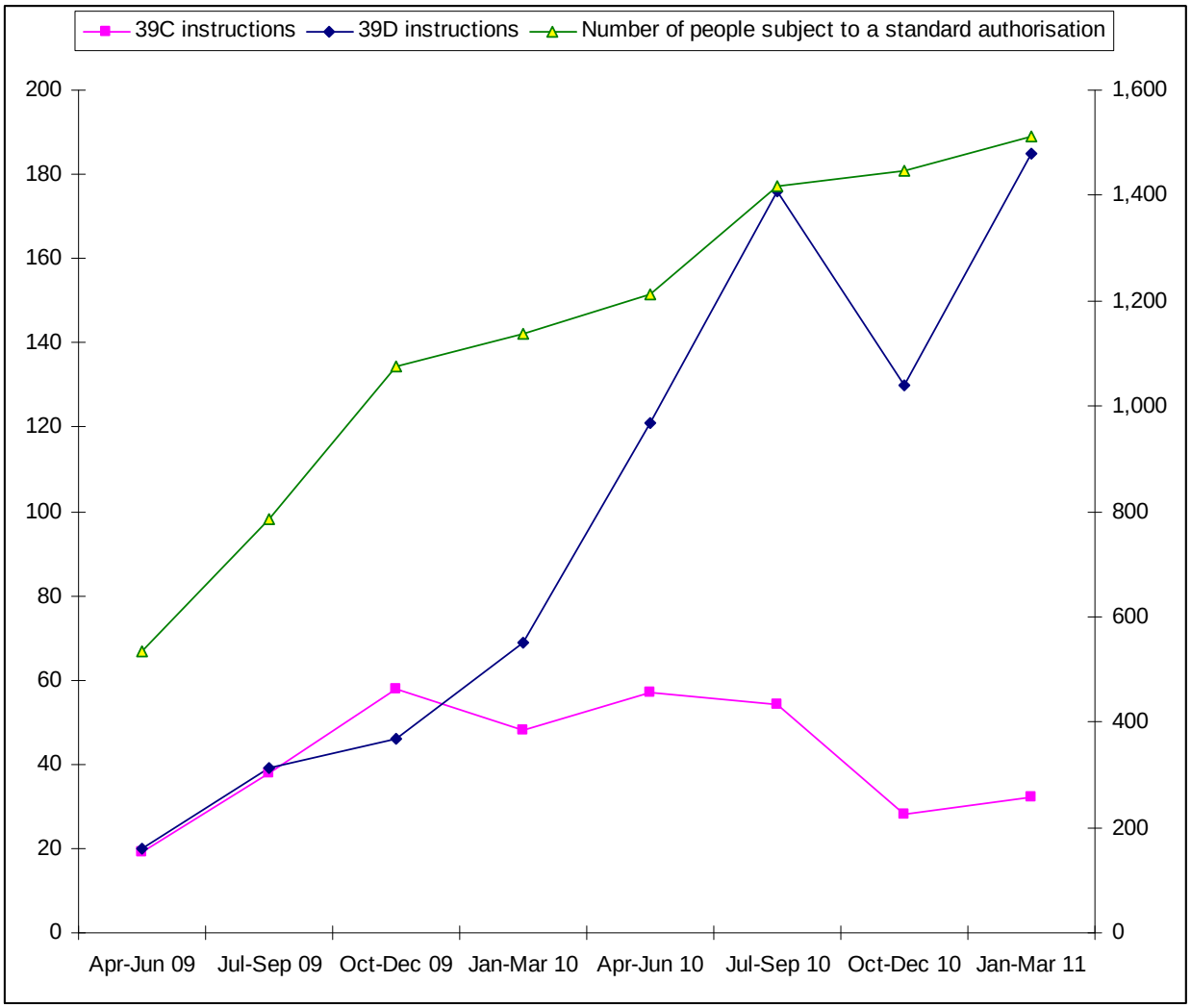
The 39D IMCA is an important safeguard to ensure both the person and their relevant person's representative understands their rights when an authorisation is in place.

These include the rights to have the authorisation reviewed, and access to the Court of Protection. The increased use of 39D IMCAs is welcomed. The second table in the appendix shows which local authorities are high users of 39D.

However in the fourth year there were only six hundred and twelve 39D IMCA instructions compared to 4951 standard authorisations being granted. This means that at most 12% of people subject to these new authorisations benefited from the support of a 39D IMCA.

The actual percentage will be lower because more that one 39D instruction can be made during a standard authorisation, and some of these 612 instructions will be in relation to authorisations granted in the previous year.

Table 15: Section 39C and 39D instructions by quarter



The ADASS/SCIE good practice guide covering this area recommends for *"supervisory bodies to instruct 39D IMCAs at the start of all standard authorisations where a person has a family member or friend appointed as their representative. This gives the person and their representative the opportunity to meet a 39D IMCA and so that they are in a better position to decide if they need the support of one at that point, or sometime in the future. "*

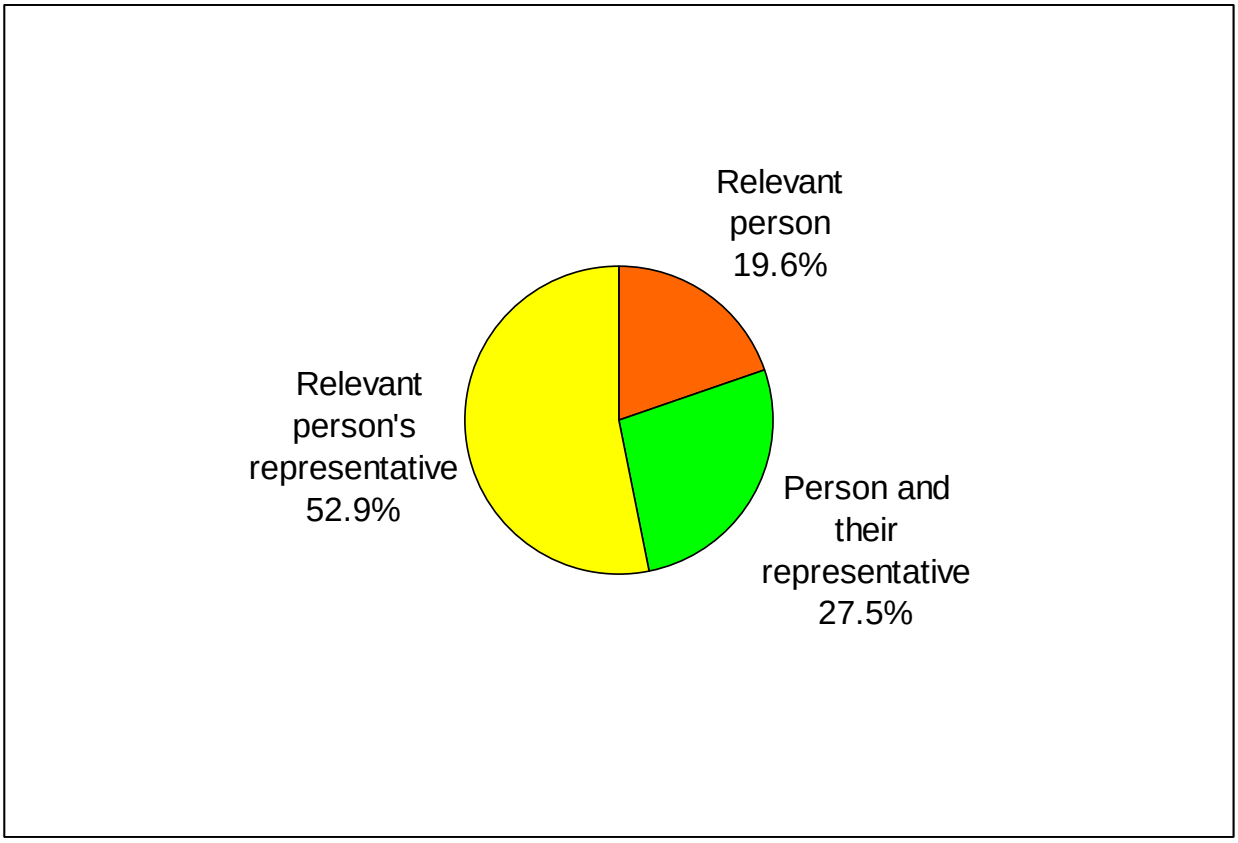
It is possible that early instruction of a 39D IMCA in the Stephen Neary case[5] may have ended his unlawful deprivation of liberty sooner. Specifically the IMCA could have explained and supported his father (who had been appointed as the relevant person's representative) about his right to challenge the authorisation in the Court of Protection without cost.

Table 16 shows the reason recorded for the 612 section 39D IMCA instructions in year 4. They may be instructed by the supervisory body because the person or their relevant person's

[5] Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP). Available on www.bailii.org

representative requests this support, or because the supervisory body believes that it would be of benefit to either or both.

Table 16: Who 39D IMCAs were requested to support



In contrast to the 39D instructions, there is a downward trend in the number of 39C instructions as a proportion of people who were subject to a standard authorisation at the end of the quarter (table 15). For example, the last two quarters of year 4 saw the lowest rates of 39D instructions across the two years at 1.9% and 2.1% respectively.

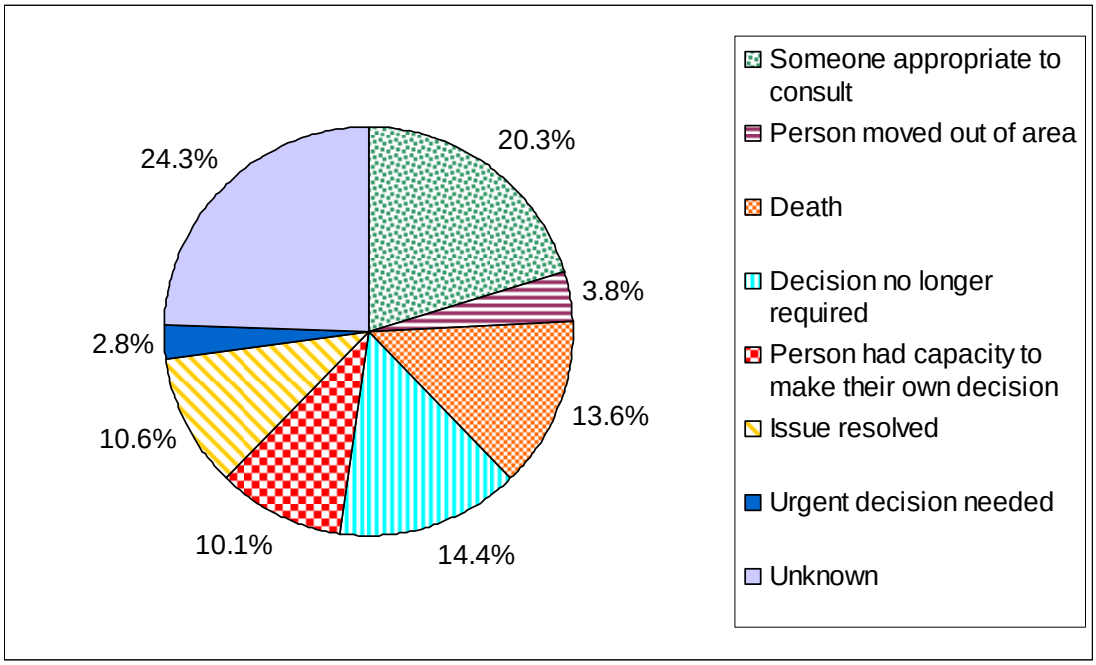
This trend probably reflects both IMCA providers and supervisory bodies gaining a better understanding of the very rare circumstances when the requirements for 39C IMCA instruction will be met.

Specifically there first needs to have been a family member or friend who has been appointed as the relevant person's representative, but is either unwilling or unable to continue in this role. Secondly there needs to be no one else available in the person's network who could step into this role. It is possible that in many cases where a 39C IMCA has been instructed, the supervisory body, to comply with the legislation, should have instead appointed a paid relevant person's representative.

11. IMCA reports

IMCAs are required to produce a report for the person instructing them. There is a legal requirement for these reports to be taken account of when decisions are being made. IMCA reports were provided for 72.6% of the 8190 eligible year 4 instructions which had been marked closed by the time this data was drawn on the 19th September 2011. Table 17 show the reasons why reports were not provided for 24.2% of these closed cases. Whether a report was produced was not identified in the remaining cases (3.3%).

Table 17 Why IMCA reports were not provided



In 30.4% of cases where a report was not submitted, the IMCA was withdrawn as the person was found not to be eligible because either they had someone appropriate to consult (20.3%) or had capacity to make the decision for themselves (10.1%). These figures are similar to closed cases from year 3 which are 20.5% and 13.3% respectively.

12. Formal actions taken by IMCAs

IMCAs will at times have concerns about a decision being made, including how the person is involved in the decision making process. The expectation is that the IMCA will raise these concerns with those involved with the hope that differences can be resolved informally. Where this is not achieved the MCA allows IMCAs to take formal action. This may include formal complaints or an application to the Court of Protection.

Amongst the eligible cases instructed during year 4, there were 13 formal complaints recorded. Of these, 9 were complaints made against the local authority, the other 4 against an NHS

body. There were 4 cases where the action of IMCAs led to applications to the Court of Protection. It is not recorded who made these applications (for example, the IMCA, the person, the local authority, or the NHS Body). The Code of Practice says that where there are disputes, local authorities or NHS bodies should make the application (8.8). The figures for year 3 are higher with 15 local authority complaints, 6 NHS complaints and 6 applications to the Court of Protection.

It cannot be concluded from these figures that there has been a significant reduction in IMCAs taking formal action over these two years. There may be a failure of some IMCA providers to record these outcomes and also 23.7% of eligible instructions for year 4 were not recorded as closed and so formal action could still be taken in these cases (17.8% of eligible instructions from year 3 are still recorded as being open). The high proportion of cases which remain open may also reflect a weakness for some IMCA providers in completing records on the database.

13. Quality

The Department of Health supported a number of initiatives to promote the quality of IMCA services during this period. While the IMCA services are locally commissioned and locally accountable, it is important to recognise that the work is statutory across England and Wales.

The national initiatives supported included:

- The development by Action for Advocacy of an IMCA specific review for the Quality Performance Mark for advocacy services which the majority of the IMCA services signed up to. This is a two part review – the first part based on self assessment in relation to a list of indicators while the second is based on an assessment of evidence provided, including anonymised IMCA reports.

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

- Good practice guides published by ADASS and SCIE on:

  Accommodation decisions and care reviews

  http://www.scie.org.uk/publications/guides/guide39/about.asp

  Access to the Court of Protection

  http://www.scie.org.uk/publications/guides/guide42/

  The IMCA roles within the Deprivation of Liberty Safeguards

  http://www.scie.org.uk/publications/guides/guide41/

  Commissioning IMCA services (revision)

  http://www.scie.org.uk/publications/guides/guide31/

- Good practice guide on serious medical treatment decisions published by Action for Advocacy

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

The previous IMCA annual report drew attention to the development of an advocacy qualification which includes two specialist modules for IMCAs. Information collected from eight of the qualification providers at the end of March 2011 showed progress in uptake. Over 225 IMCA had at that time been registered for the qualification. Of these over 75 IMCA had successfully completed the first IMCA module and 35 the Deprivation of Liberty Safeguards module.

IMCAs continued to be involved in cases taken to the Court of Protection. A significant published Court judgement was positive about the work of the IMCAs in the case.

The 'quality' issue raised with the Department during the year was the issue of the length and complexity of referral forms. Several local authorities and hospitals questioned whether it was necessary for some of the IMCA organisations to have long referral forms and to request information such as copies of capacity assessments. Some reported that this acted as a deterrent for making referrals.

The Department's view has always been that referral forms should be short and simple and should not request additional documentation. Referrals to IMCA services need to be quick and easy. Information can and should be collected as the case is progressed and should not act as a barrier to making a referral. The Department will be looking at local IMCA referral forms in the near future.

Research

Research into the difference IMCAs makes to the lives of individuals and the knowledge and practice of health and social care workers was commissioned by the Social Care Institute for Excellence and undertaken by the Norah Fry Research Centre at the University of Bristol.

http://www.scie.org.uk/publications/imca/files/IMCAreportFINALv35.pdf

This study suggested IMCAs had some significant impacts on the decision making process and on the outcome.

In relation to the *decision making process*, it was felt that in 60% of the cases IMCA involvement had made a significant difference:

- IMCAs were providing additional input to enhance and support clients' communication, to enable their wishes and feelings to be heard;

- IMCAs were identifying new information, for example that they had family or friends;

- IMCAs were providing practical, emotional and social support;

- IMCAs also reported a significant impact on the knowledge and practice of other professionals;
- IMCAs reported playing a significant role as educators/disseminators of information on the MCA.

In relation to outcomes, the research found that IMCA involvement could make a significant difference in some 52% of cases. In particular:

- IMCAs were thought to ensure that decisions were timely and based on thorough assessments of options;

- In serious medical treatment decisions, the data suggested that IMCAs played a role in bringing a holistic, person centred angle to the clinical decision making process. In particular IMCAs helped to broaden clinical thinking about how adjustments could be made to treatment to reflect a person's needs and wishes.

- In safeguarding cases, IMCAs reported their involvement led to additional personalised outcomes for clients, and assisted in clarifying misunderstandings.

Additionally, the research identified that the IMCA role brought about wider benefits:

- IMCAs were regular and visible visitors to a range of health and social care settings. Their awareness of the rights of people under the MCA, coupled with their specialist knowledge about poor practice, meant they were in a strong position to provide additional assistance, not just for their individual client, but for other people using services at the same settings.

Finally, IMCAs were found to be playing a practical role in researching and delivering quality and up to date information about casework, and representing this in a professional and time limited way to the decision maker and others involved in the decision-making process. The authors concluded that

> *"IMCAs were aware of the need to value relationships with clients, as well as results, and that paying attention to the interplay between process and outcome is key to delivering a quality service that makes a real difference to people's lives".*

Appendix: IMCA Instructions by local authority 2010-2011

The two tables below contain the number of eligible IMCA instructions by local authority in year 4 (Table 1 - data drawn on the 19th September 2011).

	SMT	Accommodation	Adult Protection	Care Review	DOLS	Unknown	Total
BARKING & DAGENHAM	4	20	8	10	14	5	61
BARNET	4	38	6	5	1	3	57
BARNSLEY	5	16	6		27	2	56
BATH & NORTH EAST SOMERSET UA	6	31	2	13	1	8	61
BEDFORDSHIRE	4	10	10	3	12	2	41
BEXLEY	2	6	2		1		11
BIRMINGHAM	46	85	36	5	23	1	196
BLACKBURN WITH DARWEN UA		10	12	2	20		44
BLACKPOOL UA	14	19	4	4	8		49
BOLTON	9	23	3	2	21	7	65
BOURNEMOUTH UA	7	55	8	1	7	1	79
BRACKNELL FOREST UA	3	6	1	11	3		24
BRADFORD	41	40	15	2	10	11	119
BRENT		22	3	1	10		36
BRIGHTON & HOVE UA	29	56	37	13	6	2	143
BRISTOL UA	44	85	20	12	40	6	207
BROMLEY	1	21	1		1		24
BUCKINGHAMSHIRE	3	29	4				36
BURY	7	16	6	2	16	1	48
CALDERDALE	14	20	5	1	5	2	47
CAMBRIDGESHIRE	12	31	20	3	9	3	78
CAMDEN	29	64	23	4	9	1	130

CHESHIRE	14	31	18	10	14	1	88
CITY OF LONDON	2	2			1		5
CORNWALL	27	87	29	21	5	6	175
COVENTRY	11	15	7	2	4	2	41
CROYDON	14	52	13	1	1	1	82
CUMBRIA	18	40	10	24	15	1	108
DARLINGTON UA	2	25	14	1	4		46
DERBY UA	10	20	19	6	14	13	82
DERBYSHIRE	22	42	53	19	62	24	222
DEVON	13	69	16	13	14	3	128
DONCASTER	4	20	8	3	2	1	38
DORSET	18	64	13	7	19	3	124
DUDLEY	11	18	11	2	15	3	60
DURHAM	7	47	12	3	21		90
EALING	1	11		2	3	2	19
EAST RIDING OF YORKSHIRE UA	2	22	5	6		1	36
EAST SUSSEX	52	70	40	12	30	6	210
ENFIELD	10	32	17	2	8	3	72
ESSEX	24	79	54	7	56	4	224
GATESHEAD	6	20	8	5	27	2	68
GLOUCESTERSHIRE	22	114	26	14	69	2	247
GREENWICH	1	12	2			1	16
HACKNEY	10	19	14	4	5	1	53
HALTON UA	3	4	5	1	4	2	19
HAMMERSMITH & FULHAM	3	10	1				14
HAMPSHIRE	28	47	18	2	20	38	153
HARINGEY	4	22	6	4	2	1	39
HARROW		5	3		2	1	11
HARTLEPOOL UA	3	15	4	1	9		32
HAVERING	9	33	3	3		3	51
HEREFORDSHIRE UA	2	24	10	3	2	1	42
HERTFORDSHIRE	20	48	30	8	20	8	134
HILLINGDON	2	6	1			1	10
HOUNSLOW		7	2	1	3		13

ISLE OF WIGHT UA	1	1	6			12	20
ISLINGTON	7	31	14	11	4		67
KENSINGTON & CHELSEA	4	14	2		15	1	36
KENT	42	66	15	31	20	105	279
KINGSTON UPON HULL UA	15	16	9	8	1	2	51
KINGSTON UPON THAMES	5	33			2	2	42
KIRKLEES	18	49	44	12	1	7	131
KNOWSLEY	1	7	2	2	11		23
LAMBETH	12	38	4	2	9		65
LANCASHIRE	27	78	37	26	54		222
LEEDS	35	120	58	20	27	4	264
LEICESTER UA	15	39	8	5	24	6	97
LEICESTERSHIRE	10	28	6	11	27	5	87
LEWISHAM	11	21	2	1	1	1	37
LINCOLNSHIRE	3	34	2	3	22	14	78
LIVERPOOL	49	52	15	15	27	16	174
LUTON UA	1	21	15		11	5	53
MANCHESTER	14	103	10	9	26	25	187
MEDWAY TOWNS UA	3	11	3	2	5	10	34
MERTON	2	12	1	2	6	1	24
MIDDLESBROUGH UA	7	22	8	2	7	1	47
MILTON KEYNES UA	2	10	4	1		3	20
NEWCASTLE UPON TYNE	13	38	11	4	7		73
NEWHAM	3	34	6	7	4	3	57
NORFOLK	28	53	16	6	4	1	108
NORTH EAST LINCOLNSHIRE UA	9	21	3	3	2	2	40
NORTH LINCOLNSHIRE UA	3	12	1	1	13		30
NORTH SOMERSET UA	17	23	20	1	9	1	71

NORTH TYNESIDE	9	19	13	11	2		54
NORTH YORKSHIRE	16	72	27	8	9	9	141
NORTHAMPTONSHIRE	6	51	16	22	11	8	114
NORTHUMBERLAND	9	15	11	4	4		43
NOTTINGHAM UA	7	35	20	6	20	1	89
NOTTINGHAMSHIRE	8	33	11	2	30	4	88
OLDHAM	5	9	5	4	2		25
OXFORDSHIRE	8	38	14	1	70	1	132
PETERBOROUGH UA		19	1	1	5		26
PLYMOUTH UA	21	60	16	17	12	2	128
POOLE UA	5	31	4		9	1	50
PORTSMOUTH UA	6	13	2		7	1	29
READING UA	8	18	2	2	10		40
REDBRIDGE	4	17	4	4	5	3	37
REDCAR & CLEVELAND UA	4	10	13	1	3		31
RICHMOND UPON THAMES		7		1		1	9
ROCHDALE	2	27	4		4	9	46
ROTHERHAM	1	19	7	1	6	3	37
RUTLAND UA	1		1		1		3
SALFORD	4	18	3	8		2	35
SANDWELL	8	15	9	5	9	2	48
SEFTON	4	20	5	6	1	2	38
SHEFFIELD	12	49	5	5	13	3	87
SHROPSHIRE	2	10	3	3	8	1	27
SLOUGH UA	2	12	3	1	1		19
SOLIHULL	6	18	7	6	1	2	40
SOMERSET	18	44	22	6	25		115
SOUTH GLOUCESTERSHIRE UA	17	23	6	3	26	2	77
SOUTH TYNESIDE	8	23	13	19	12		75
SOUTHAMPTON UA	26	48	3		20	1	98

SOUTHWARK	3	21	5	1	11	2	43
ST HELENS		5	3	1	1		10
STAFFORDSHIRE	16	38	15	3	29	3	104
STOCKPORT	10	20	4	4		2	40
STOCKTON ON TEES UA	7	8	4	2	5	2	28
STOKE-ON-TRENT UA	14	15	3	1	5	4	42
SUFFOLK	24	96	26	25	21	9	201
SUNDERLAND	11	19	7	1	12	13	63
SURREY	94	149	6	10	6	11	276
SUTTON	2	24	13	8	3	1	51
SWINDON UA	9	12	7	3	11	5	47
TAMESIDE	8	15	6	2	4	1	36
TELFORD & WREKIN UA	3	10	2	3	2	3	23
THURROCK UA		8	8		5	2	23
TORBAY UA	11	16	12		4	2	45
TOWER HAMLETS	9	37	9	2	9	1	67
TRAFFORD	4	27	1	1	1	6	40
WAKEFIELD	23	37	22	3	11	4	100
WALSALL	3	3	8	1	2	4	21
WALTHAM FOREST	5	29	8	7	7	1	57
WANDSWORTH	18	47	12	4	4		85
WARRINGTON UA	5	13	8	2	4	3	35
WARWICKSHIRE	14	26	4	2	6	2	54
WEST BERKSHIRE UA	2	4	2	3			11
WEST SUSSEX	15	65	12	14	30	14	150
WESTMINSTER	2	19	1	1	5	1	29
WIGAN	20	34	14	12	56	8	144
WILTSHIRE	15	19	10	3	16	1	64
WINDSOR & MAIDENHEAD UA		10	4	5	19		38
WIRRAL	8	28	5	2	1	15	59

WOKINGHAM UA	2	1		1	1		5
WOLVERHAMPTON	3	17	12	3	6	1	42
WORCESTERSHIRE	17	32	10	4	8	2	73
YORK UA	10	31	9	4	4	4	62
Total	1,630	4,530	1,548	751	1,669	602	10,730

Type of DOLS IMCA Instructions for year 4 eligible instructions (data drawn 15th November 2011)	39A	39C	39D	Total
BARKING & DAGENHAM	7	3	4	14
BARNET	1	0	0	1
BARNSLEY	15	7	5	27
BATH & NORTH EAST SOMERSET UA	0	0	1	1
BEDFORDSHIRE	5	2	5	12
BEXLEY	1	0	0	1
BIRMINGHAM	12	5	6	23
BLACKBURN WITH DARWEN UA	9	0	11	20
BLACKPOOL UA	7	0	1	8
BOLTON	2	1	16	19
BOURNEMOUTH UA	6	0	1	7
BRACKNELL FOREST UA	1	1	1	3
BRADFORD	5	0	5	10
BRENT	4	0	6	10
BRIGHTON & HOVE UA	3	1	1	5
BRISTOL UA	7	6	24	37
BROMLEY	1	0	0	1

BUCKINGHAMSHIRE	0	0	0	0
BURY	6	8	2	16
CALDERDALE	3	1	1	5
CAMBRIDGESHIRE	4	0	4	8
CAMDEN	8	0	1	9
CHESHIRE	13	1	0	14
CITY OF LONDON	1	0	0	1
CORNWALL	1	0	4	5
COVENTRY	4	0	0	4
CROYDON	0	1	0	1
CUMBRIA	7	4	4	15
DARLINGTON UA	2	0	2	4
DERBY UA	15	0	0	15
DERBYSHIRE	54	0	8	62
DEVON	5	4	5	14
DONCASTER	2	0	0	2
DORSET	5	1	13	19
DUDLEY	9	0	6	15
DURHAM	12	3	6	21
EALING	2	1	0	3
EAST RIDING OF YORKSHIRE UA	0	0	0	0
EAST SUSSEX	13	4	13	30
ENFIELD	7	1	0	8
ESSEX	28	0	28	56
GATESHEAD	4	1	22	27
GLOUCESTERSHIRE	33	0	36	69
GREENWICH	0	0	0	0

HACKNEY	3	1	1	5
HALTON UA	2	1	1	4
HAMMERSMITH & FULHAM	0	0	0	0
HAMPSHIRE	10	0	10	20
HARINGEY	1	1	0	2
HARROW	2	0	0	2
HARTLEPOOL UA	3	6	0	9
HAVERING	1	0	0	1
HEREFORDSHIRE UA	1	0	1	2
HERTFORDSHIRE	3	3	14	20
HILLINGDON	0	0	0	0
HOUNSLOW	2	0	1	3
ISLE OF WIGHT UA	0	0	0	0
ISLINGTON	4	0	0	4
KENSINGTON & CHELSEA	7	1	7	15
KENT	13	1	7	21
KINGSTON UPON HULL UA	1	0	0	1
KINGSTON UPON THAMES	1	0	1	2
KIRKLEES	1	0	0	1
KNOWSLEY	4	5	2	11
LAMBETH	3	4	2	9
LANCASHIRE	30	1	23	54
LEEDS	13	2	12	27

LEICESTER UA	23	1	0	24
LEICESTERSHIRE	15	7	5	27
LEWISHAM	1	0	0	1
LINCOLNSHIRE	9	1	12	22
LIVERPOOL	10	1	17	28
LUTON UA	5	0	6	11
MANCHESTER	21	4	1	26
MEDWAY TOWNS UA	5	0	0	5
MERTON	4	2	0	6
MIDDLESBROUGH UA	5	1	1	7
MILTON KEYNES UA	0	0	0	0
NEWCASTLE UPON TYNE	5	2	0	7
NEWHAM	4	0	0	4
NORFOLK	2	0	1	3
NORTH EAST LINCOLNSHIRE UA	2	0	0	2
NORTH LINCOLNSHIRE UA	9	3	1	13
NORTH SOMERSET UA	2	0	7	9
NORTH TYNESIDE	1	0	1	2
NORTH YORKSHIRE	5	2	2	9
NORTHAMPTONSHIRE	6	5	0	11

NORTHUMBERLAND	3	0	1	4
NOTTINGHAM UA	13	0	7	20
NOTTINGHAMSHIRE	21	1	7	29
OLDHAM	1	0	1	2
OXFORDSHIRE	3	3	64	70
PETERBOROUGH UA	1	0	4	5
PLYMOUTH UA	9	0	3	12
POOLE UA	4	0	5	9
PORTSMOUTH UA	3	1	3	7
READING UA	7	0	3	10
REDBRIDGE	4	0	1	5
REDCAR & CLEVELAND UA	3	0	0	3
RICHMOND UPON THAMES	0	0	0	0
ROCHDALE	2	0	2	4
ROTHERHAM	4	2	0	6
RUTLAND UA	1	0	0	1
SALFORD	0	0	2	2
SANDWELL	8	1	0	9
SEFTON	1	0	0	1
SHEFFIELD	9	1	3	13
SHROPSHIRE	5	1	2	8
SLOUGH UA	1	0	0	1
SOLIHULL	0	0	1	1
SOMERSET	6	0	19	25

SOUTH GLOUCESTERSHIRE UA	6	2	18	26
SOUTH TYNESIDE	2	2	8	12
SOUTHAMPTON UA	10	4	6	20
SOUTHWARK	3	3	5	11
ST HELENS	1	0	0	1
STAFFORDSHIRE	16	10	3	29
STOCKPORT	0	0	0	0
STOCKTON ON TEES UA	3	1	1	5
STOKE-ON-TRENT UA	5	0	0	5
SUFFOLK	15	0	6	21
SUNDERLAND	1	1	11	13
SURREY	6	0	0	6
SUTTON	2	1	0	3
SWINDON UA	4	0	5	9
TAMESIDE	3	1	0	4
TELFORD & WREKIN UA	2	0	0	2
THURROCK UA	3	1	1	5
TORBAY UA	4	0	0	4
TOWER HAMLETS	5	1	3	9
TRAFFORD	3	0	0	3
WAKEFIELD	7	0	4	11
WALSALL	1	0	1	2

WALTHAM FOREST	3	2	2	7
WANDSWORTH	2	2	0	4
WARRINGTON UA	2	0	2	4
WARWICKSHIRE	4	0	2	6
WEST BERKSHIRE UA	0	0	0	0
WEST SUSSEX	11	9	10	30
WESTMINSTER	2	0	3	5
WIGAN	48	4	2	54
WILTSHIRE	10	0	5	15
WINDSOR & MAIDENHEAD UA	9	3	7	19
WIRRAL	1	0	0	1
WOKINGHAM UA	1	0	0	1
WOLVERHAMPTON	4	2	0	6
WORCESTERSHIRE	1	1	6	8
YORK UA	3	0	1	4

There are some minor differences from the previous table in the total due to this data being collected at a slightly later date as some providers have added data.

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