Department of Health

The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service: 2012/2013

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The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service: 2012/2013

Prepared by Lucy Bonnerjea

Executive summary

Introduction

This report is the sixth annual report on the Independent Mental Capacity Service and covers the period April 2012 to March 2013. It also provides an overview of the six years that the IMCA service has been in existence.

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service to empower and safeguard people who do not have 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 and to consider their views before decisions are made..

The role of the IMCA is to support and represent people at times when critical decisions are being made about their health or social care. They are involved when the person lacks capacity to make these decisions themselves and mainly when they do not have family or friends who can represent them. The Deprivation of Liberty Safeguards (DOLS) were implemented on the 1st April 2009. IMCAs have an important role to support people who may be subject to these safeguards.

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 information recorded on this database, and was collected on the 27th August 2013 and the 23th October 2013.

Key results

During the sixth year there were 12,381 eligible instructions for the IMCA service in England.

This is a 4% increase from the published figures for the previous year.

Breakdown by decision type, together with the percentage change from last year:

- Accommodation decisions 5,353 (9% increase)
- Serious medical treatment decisions 1,907 (9% increase)
- Care reviews 1,203 (16% increase)
- Adult protection/Safeguarding 1,482 (3% decrease)
- Deprivation of Liberty Safeguards 1,907 (3% decrease)

There has been a year on year increase in instructions to the IMCA service since the service began in 2007 (when there were 5266 cases).The numbers have more than doubled in the six years.

There continue to be 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.

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'/ adult protection 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.

Accommodation decisions

Accommodation cases remain the largest category of referrals; these show a 9% increase from the previous year.

Serious Medical Treatment

The number of referrals for IMCAs to be involved in serious medical treatment decisions has increased by 9%.This appears to reflect a better understanding of the role of the IMCA in end of life care for people with dementia.

Safeguarding

For the second year, there has been a decline in the number of cases where IMCAs have been representing people who were subject to safeguarding.

There were 1,482 safeguarding IMCA referrals, while national safeguarding data collected by local authorities shows there were over 173,000 reported safeguarding alerts in the last year.

This means fewer than 1% of people who were referred to local authorities for safeguarding assistance received the help of an IMCA. This proportion is decreasing as safeguarding numbers increase and IMCA supported safeguarding decreases.

Care Reviews

The number of instructions for care reviews has shown an increase of 9%. However it continues to be low in absolute numbers, in comparison to accommodation decisions.

There is approximately one care review referral for each five accommodation referrals.

This raises questions:

- Are care reviews being consistently undertaken after moves?
- Why are four thousand people not receiving an IMCA to support and represent the person in 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 Trust within three months of the decision to provide continuing care, and then at least annually.

DOLS

Deprivation of Liberty Safeguards instructions showed a decrease of 3%.

Reflections

IMCAs are asked to reflected on their cases, their successes and their obstacles and to input their reflections in the database.

The obstacles that IMCAs identified to good practice included:

- the lack of effective communication with referrers;
- delays by decision makers in taking action
- lack of clarity on who the decision maker was
- lack of a working-together ethos within safeguarding

IMCAs identified the following obstacles to the improvement of their own work: the threat of a change of provider through re-tendering, the size of their case loads, and the pressure to spend less time with each client *leading to less supported decision making*.

The outcomes for people, identified by IMCAs included:

- improved decision making process
- increased liberty or autonomy
- identification of new issues
- provision of specialist knowledge or questioning
- different and better outcomes.

Court of Protection

Court of Protection judgements continue to be important in guiding decision making.

The case of *DE illustrates how* important it is:

i) to seek evidence that 'all practicable steps' have been taken to help people make their own decisions and
ii) for staff not just to seek a DOL authorisation, but also to actively promote the liberty of people within care planning.

Recommendations

1. It is recommended that commissioners recognise that the number of people statutorily eligible for the IMCA service continues to increase on a year-by-year basis, and that they reflect on the issues discussed in Chapter 11.

2. It is recommended that local authorities and IMCA organisations both carry out self audits of recent accommodation moves, and ensure that people's wishes and feelings have been considered and the issue of 'less restriction' has been fully reflected in all decisions.

3. It is recommended that IMCA organisations, local authorities and the NHS continue to be alert to possible Deprivations of Liberty (DoL). IMCA organisations should alert local authorities and the NHS for the need either to prevent a DoL by changing the care plan, or applying the DoL safeguards, in a care home or hospital. If the possible DOL is the result of a care package in the community, a referral to the Court of Protection is required. Introducing the heading 'liberty' into *all* care plans, to assist staff to consider ways of promoting liberty as part of care planning is good practice.

4. It is recommended that local authorities carry out a small audit of recent reviews, to establish whether all those who would benefit from IMCAs in their Reviews did receive one.

5. It is recommended that Mental Capacity Act leads in CCGs monitor compliance with the requirement for referrals to IMCAs for each of their providers, as part of their MCA responsibilities.

6.It is recommended that local authority safeguarding coordinators consider the statistics in this report and report to their Safeguarding Adults Boards on whether sufficient number of IMCA referrals are being made in their areas.

7.It is recommended that supported decision making is adopted more widely within safeguarding practice, to assist more people to make their own decisions about their safeguarding plans. And before a care plan or a protection plan is made, the question should always be asked about whether any less restrictive safeguarding action which would interfere less with the person's basic rights and freedoms may be possible.

8. It is recommended that IMCAs and commissioners audit a sample of IMCA reports, possibly using the tool designed by Empowerment Matters, reproduced here on pages 67 and 68.

9. It is recommended that IMCAs follow Court of Protection advice in published judgements on identifying a possible DOL and on applying the MCA principles in relation to all care planning.

IMCA Case Study

Kemar is a 35 year old man with Learning Difficulties and Epilepsy who, until recently, lived happily and independently in the community. With support he was able to do his own shopping, manage his finances and enjoy an active and varied social life in his local community.

This all changed following a recent stroke, which saw Kemar admitted to hospital. Despite physiotherapy, his mobility remained limited and it was thought that he would be unable to return to his previous living arrangements. He was assessed as being without capacity to make a decision regarding his change of accommodation and had no family or friends to represent him, so a referral to the IMCA service was made.

The social worker had identified a placement for Kemar in a residential home and contacted the IMCA to advise he would be transferred the next day. The IMCA requested that before he was moved they visit the property to assess its suitability. The visit took place and the IMCA found the home was very small, two of the three residents were unable to communicate, and Kemar would have to remain in a wheelchair or a small bedroom for most of the day.

The IMCA fought hard to persuade the team involved that other options were available and escalated the case to the ‘cluster manager’ for review. Subsequently, Kemar was transferred to a specialist rehabilitation unit where he has since made remarkable progress. Upon discharge he will once again be able to live independently, even if that means being placed in a complex which provides supported living.

Had he not been given the opportunity of rehabilitation, Kemar would not have been able to enjoy the quality of life, the autonomy and independence he previously had.

MAIN REPORT

Section 1. The IMCA service in 2012/3

During 2012/13, the Mental Capacity Act and the Deprivation of Liberty safeguards have been under Parliamentary scrutiny.

The Health Select Committee (HSC) reported on the "Post-legislative Scrutiny of the Mental Health Act 2007" and made a number of recommendations on a wide range of issues, one of which was the Deprivation of Liberty safeguards. The Health Select Committee was particularly concerned with the 'disparity in application and authorisation rates' between local areas and a 'much lower rate of overall use of DOLS than predicted'.

The Committee noted that:

- care providers did not know when they were exceeding their powers and did not know when they needed to apply for a DOLS authorisation;
- there appeared to be a lack of understanding about the 'meaning of deprivation of liberty' in practice;
- there was also a résistance to using the DOLS.

The House of Lords also launched its own scrutiny – into the Mental Capacity Act and the Deprivation of Liberty safeguards. At the time of writing this report on the IMCA service, the committee had heard oral evidence from a large number of stakeholders. Its report is due in February or March 2014.

Parliamentary scrutiny is happening at a time when there is huge change in the NHS, with NHS England and Clinical Commissioning Groups having become the new commissioners of the health service. It is happening at a time when local authorities face demographic pressures with their ageing populations as well as financial constraints. In many local authorities there have been reorganisations and a greater focus on statutory duties.

The IMCA service operated during 2012/13 in the context both of the above Parliamentary questions and in the context of increased financial constraints.

This Report is a report on the Independent Mental Capacity Advocate (IMCA) service – and, equally importantly – on the legal duty to instruct the IMCA service in certain situations. Without instructions there can be no IMCA role in decision making, and the number of people supported by IMCAs is a reflection of the number of instructions, not on the numbers of IMCAs available.

The IMCA service started in 2007 when it provided a service for 5,266 people and has been providing a statutory service for six years. During 2012-2013, it provided a service for 12,381 people. This is an increase of 120% over the six years; and a 4 per cent increase in the last year.

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 additional criteria do 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. Two years later, IMCAs were given additional duties under the Deprivation of Liberty Safeguards.

The IMCA service is:

- unique as a statutory service provided by the voluntary sector;
- a national service provided by some 60 local providers;
- a service that aims to empower as well as to safeguard.
- accountable to local commissioners, local clients and through this national report to Parliament;
- a partner for the NHS as well as the 152 local authorities;
- designed to support and represent people; to help people make their own decisions irrespective of the seriousness of their mental impairments, as well as to speak on their behalf if they cannot do so themselves;
- a service designed to challenge and change non MCA compliant decisions and practices.

The IMCA service works on the interface of law, social care and health care, and at a time when commissioners are looking very closely at all their services, the IMCA service remains one of the organisations best placed to report to commissioners on the effectiveness of mainstream health and social care services to meet the needs of those with mental impairments.

The Deprivation of Liberty Safeguards

The Deprivation of Liberty safeguards were added to the MCA in 2007. These 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.

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.

The data

Since the IMCA service began in April 2007, IMCA providers have been recording details about cases on a national database maintained by the Health and Social Care Information Centre. This report provides information from the IMCA organisations, about recorded IMCA instructions which were made between the 1st April 2012 and the 31st March 2013.

The database records data for England and Wales. This report only includes the data for England. The data presented here were collected in August and October 2013. The data collected in August was validated by asking IMCA organisations to confirm that all data had been entered into the database; this proved not to be the case so further analyses of some of the data took place in October to ensure that the most recent data was published.

There is some slight variance with the figures contained in the earlier annual IMCA reports due to data being added late by IMCA providers. All the data in the report only refers to eligible referrals – so where an IMCA service receives a referral which is not eligible – for example because the person is under the age of 16, these referrals are mainly not progressed and not reported here. This is consistent with previous reports, where the focus is on the number of people who benefited from the service, not the referrals made.

Section 2. People who receive IMCA support and representation

Case study: Sandra

Sandra is 60 years old, with a learning disability. She had lived in her family home, with her parents, until her father passed away and her mother was moved to a nursing home with advanced dementia. Sandra had said she wanted to continue living at home with a care package, but she presented very challenging behaviour with a risk to herself and her carers and had therefore been placed in various other settings including shared lives, supported living and respite care. The social worker instructed an IMCA when looking for long term accommodation.

The IMCA talked to Sandra about what was important to her. Sandra said that she understood that returning home was difficult, 'because of the memories'. But she wanted to be near her mother and to be able to visit her regularly. She wanted to live near her mother's nursing home. She was taken to view several options and chose the home that was around the corner from the nursing home. She moved and settled quickly.

Then the nursing home announced it was going to be closed and there were two issues – where to move Sandra's mother and how this would affect Sandra. The IMCA contacted both the social worker for Sandra and the social worker for her mother, and after discussions, Sandra's mother was put on a waiting list in a home that was both appropriate for the mother and also walking distance for Sandra. The IMCA had brought 2 teams together, and assisted in facilitating a decision which upheld the Article 8 rights of both people – their right to continue to have a close relationship, and family life together, while both being placed in separate care homes.

During the year 2012/13 there were a total of 12, 381 eligible instructions for the IMCA service in England.

This figure is 4% more than the published figure in last year's report of 11,899. *Over the last two years, there has been an increase of 15%.*

The data for the 2011/12 IMCA report was extracted in October 2012 whilst the data for the 2012/13 IMCA report was extracted in August 2013 and then some tables were updated in October. The data showed an increase over the 2 months period, as IMCA providers continued to input data on on-going cases. The latest figures are those in the summary and in the appendices.

Figure.2.1 shows the total number of instructions for the first six years; it shows the number of IMCA instructions has steadily increased over the six years, with some 6,500 more people benefiting from IMCA support and representation in the last year than in the first year of the IMCA service. This represents more than 120% increase across these six years.

Figure 2.1 Number of people receiving IMCA support/representation over the last 6 years

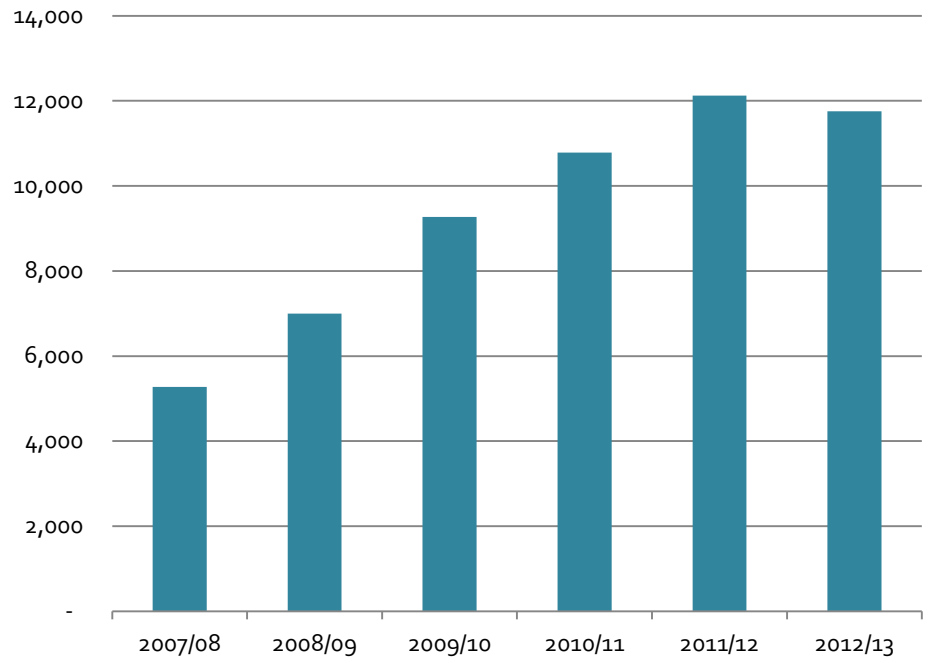


Figure 2.1 is based upon data extracted in August 2013.Between August and October the increase continued and the figures in October are now 12,381 – over the 12,000 line.

Figure 2.2 shows an increase in care reviews, in serious medical treatment decisions and in accommodation decisions. It shows a decrease in referrals for Deprivation of Liberty decisions by 3% and a similar decrease in Safeguarding/Adult Protection referrals.

Figure 2.2: Change in number of eligible referrals from 2011/12 to 2012/13

Decision type	Number of IMCA instructions	% change from 2011/12 to 2012/13
Care Review	*1,203*	*+16%*
Serious Medical Treatment	*1,907*	*+9%*
Change Accommodation	*5,353*	*+9%*
None chosen	*496*	*-3%*
Deprivation of Liberty	*1,907*	*-3%*
Safeguarding	*1,482*	*-3%*

Figure 2.3 below shows that different types of decisions that IMCAs are instructed for.

Accommodation decisions continue to dominate the work of the IMCA; there were over 5,300 accommodation decisions involving IMCAs. The accommodation decisions continue to be the largest category of decision requiring support in each year and care reviews despite having the largest increase, are still the smallest.

Figure 2.3: Number of eligible IMCA referrals by decision type, 2012/13

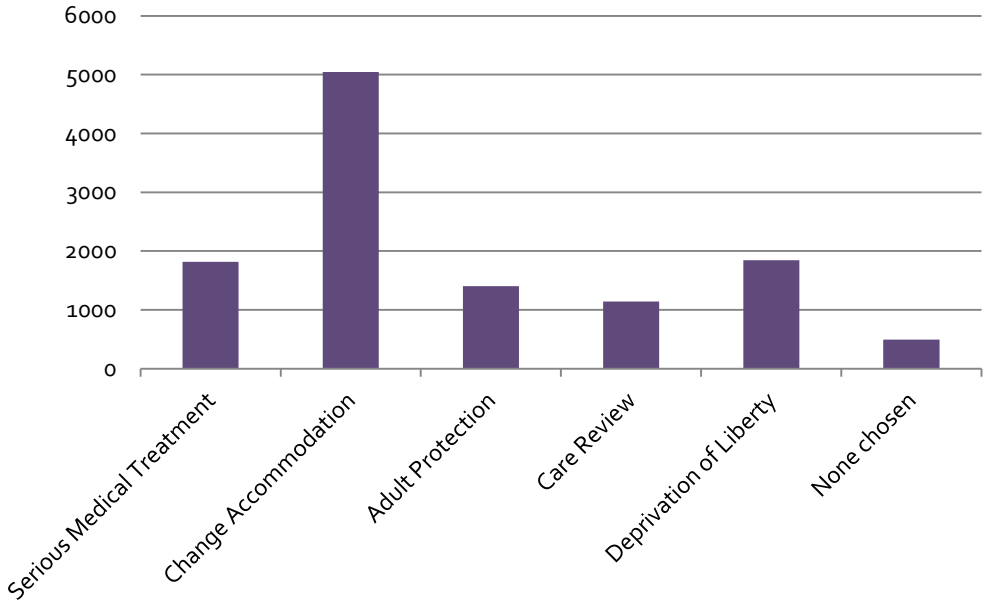


Figure 2.4 below shows the general distribution of IMCA referrals by the decision type over the last six years.

This shows that increases over the last six years have generally been proportionate and fairly evenly distributed across all decision types. 2012/13 has seen an increase in some areas and a slight decline in others.

Figure 2.4: Number of eligible IMCA referrals by decision type over the last six years

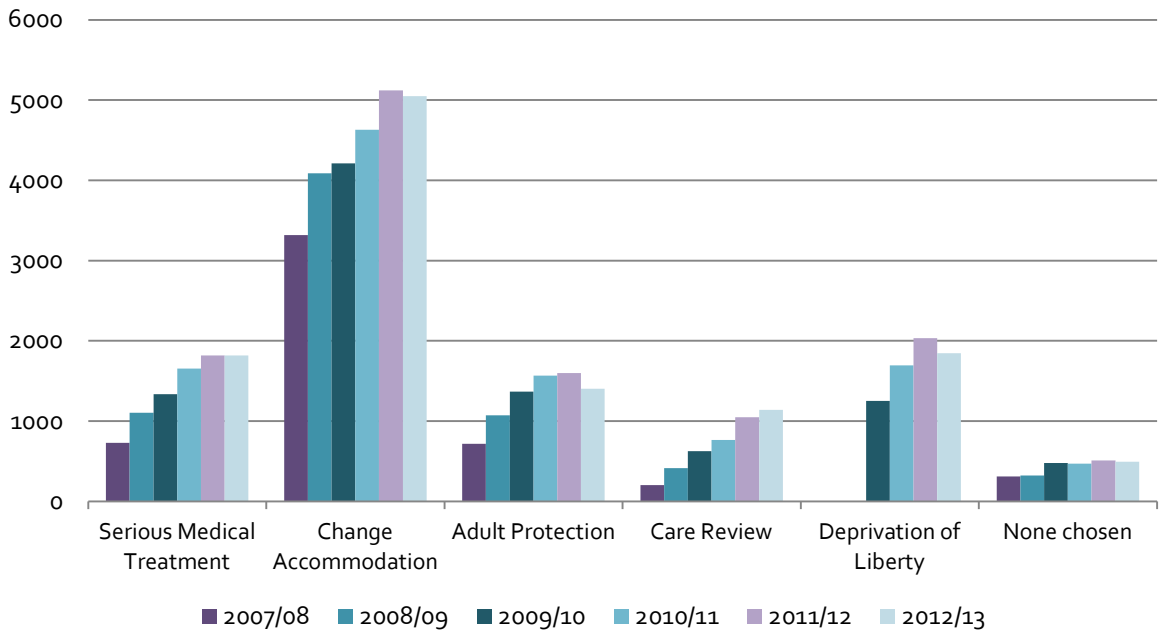
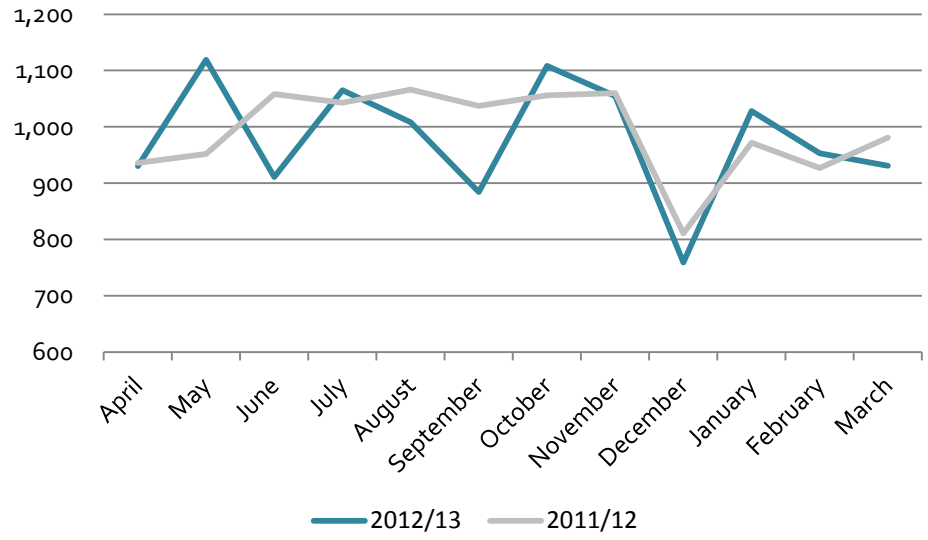


Figure 2.5 below shows the distribution of IMCA referrals by month for the past two years.

As seen last year, there is a large dip in 2012/13 during the month of December, and also dips in May and end of August. This may reflect holiday patterns (and even bank holidays) in local authorities and NHS trusts affecting levels of instructions.

This year saw a 17% increase in referrals in early May and a 15% dip in June and in September in comparison to last year.

Figure 2.5: Number of eligible IMCA referrals each month in 2011/12 and 2012/13



The people who benefit from the IMCA service

Age

There has been very little difference in age categories over the last six years.

Almost 65% of clients are over 65 years of age and 37% are aged 80 or above. The latter category, those aged 80 or above has increased at a slow but steady rate across the six years.

IMCAs can be provided to young people aged 16 and 17 and there were 31 such referrals last year. This number remains low, and has decreased from 41 in 2011/12.

The number of people receiving support from IMCAs aged 80 or over is 4,195. This is slightly lower than last year's figure of 4,342, but still higher than the 2010/11 figure of 3,809. This means one in three IMCA clients are aged over 80, and two thirds are over 65.

Figure 2.6: IMCA instruction by age profile for the last six years

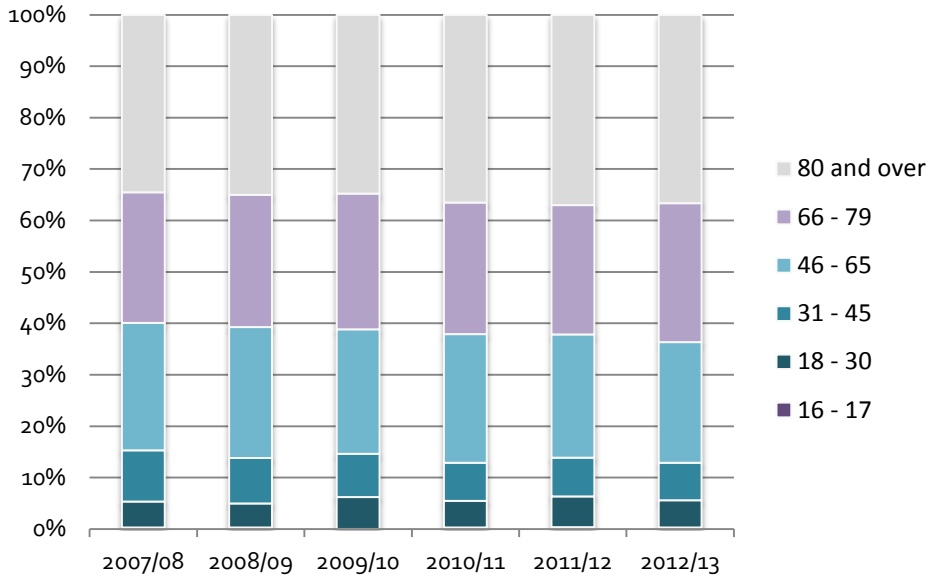


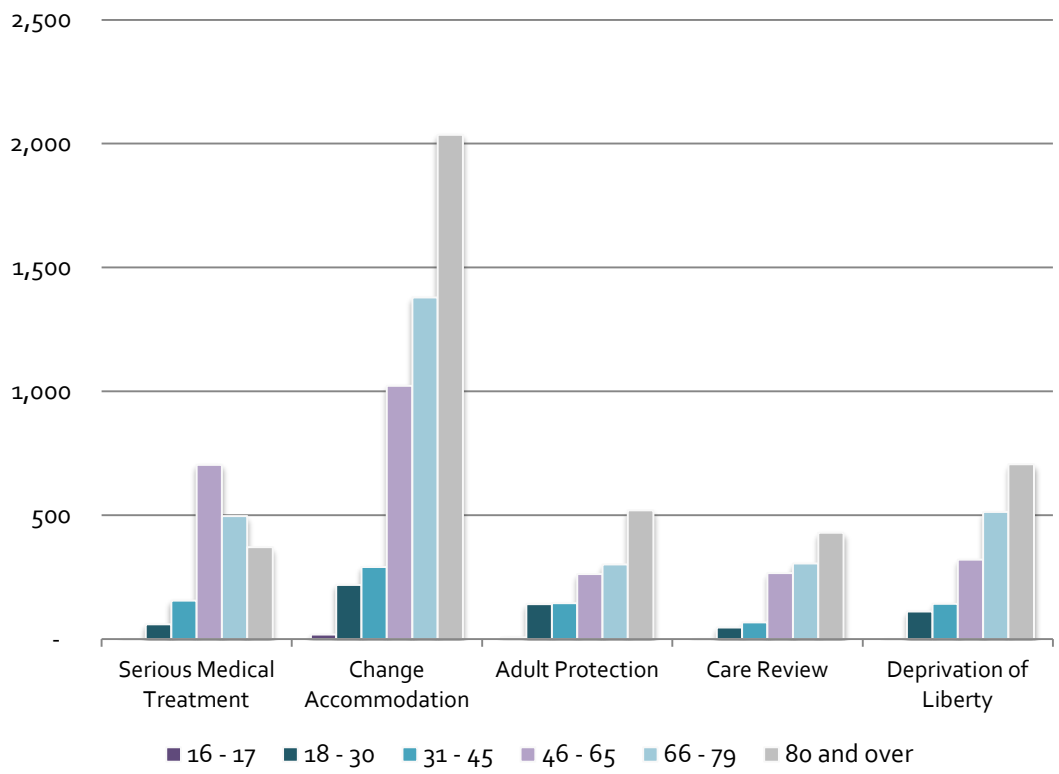
Figure 2.7 shows age variations by the reason for the IMCA instruction.

- The age profile for serious medical treatment decisions stands out as having a different age distribution to the other decision types. There are fewer older people receiving serious medical treatment in the group that receive IMCA support. Around 40% of those receiving IMCA support for serious medical treatment are aged between 46-64..

- In all other groups it is people aged 80 and above who are the largest age group. This includes the population who are subject to the Deprivation of Liberty safeguards.

- The difference between the numbers and proportions who 'change accommodation' and then go on to have a care review involving an IMCA is also surprising. Far fewer people in each of the categories carry on to have a care review.

Figure 2.7: Age profile by reason for instruction, 2012/13



Ethnicity

The distribution of ethnic origins for those receiving IMCA instructions in 2012/13 has remained very similar to the proportions in 2011/12.

Figure 2.8: Ethnicity of people receiving IMCA services, 2012/13

Ethnicity	Number receiving IMCA services	Percentage of all IMCA services
White	*10,440*	*89%*
Asian or Asian British	*313*	*3%*
Black or Black British	*331*	*3%*
Chinese	*15*	*0%*
Other	*136*	*1%*
Unknown	*516*	*4%*
Total	***11,751***	***100%***

Gender

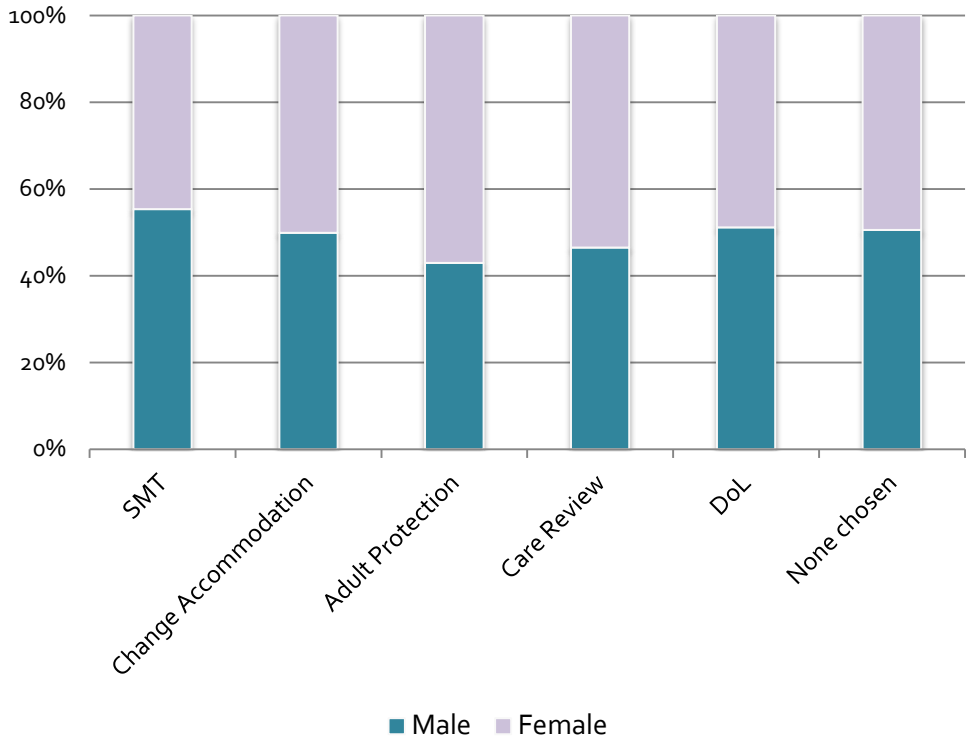
Gender differences continue to be small. Figure 2.9 shows that:

- There is a higher proportion of men (55%) receiving IMCA support for serious medical decisions than women (45%).

- For safeguarding/adult protection cases the reverse is found: 43% of the cases are men and 57% are women.

- For accommodation decisions, care reviews and DOLS there is little difference between the number of men and women being supported by the IMCA service.

Figure 2.9: Gender by Decision Type for 2012/13.



Why people may lack capacity to make decisions

The IMCA service is for people who have a mental impairment and who lack capacity in relation to a specific decision to be made. The first stage of a mental capacity assessment is to identify if a person has an impairment of the function of the brain.

Table 2.10 shows the different mental impairments that were recorded. The breakdown of IMCA referrals categorised by the mental impairment has broadly stayed the same as for the previous two years. Dementia (39%), learning disabilities (21%) and mental health problems other than dementia (13%) are the most common mental impairments for those receiving an IMCA referral.

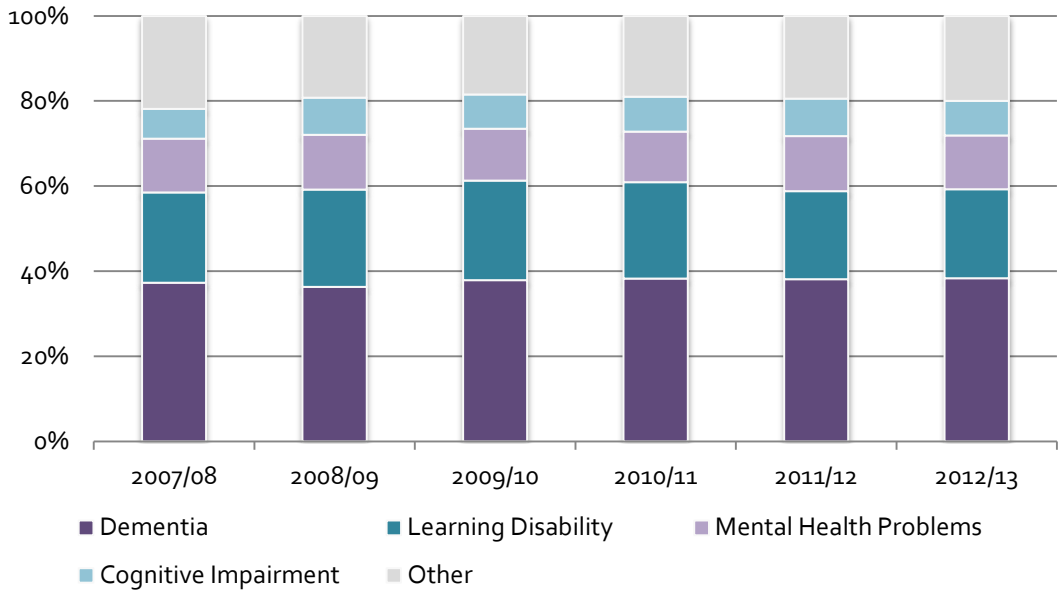
Figure 2.10: Number of IMCA cases by type of mental impairment, 2012/13
[Data for this table was extracted 31st October]

Mental Impairment	Number receiving IMCA services	Percentage of total
Dementia	4,612	39%
Learning Disability	2,505	21%
Mental Health	1,503	13%

Problems		
Cognitive Impairment	971	8%
Acquired Brain Damage	654	5%
Serious Physical Illness	488	4%
Combination	452	4%
Not Specified	263	2%
Other	239	2%
Autism Spectrum Condition	225	2%
Unconsciousness	*39*	*0%*
Total	***11,951***	**100%**

Figure 2.11 shows that the profile of mental impairment has hardly changed over the past six years, with 60% of IMCA referrals being for people with dementia or a learning disability.

Figure 2.11 : Most common impairment of IMCA service users, over the past 6 years



Section 3. Where were people when the IMCA was instructed

Sam

Sam was a young man with a Learning Disability and was also on the autistic spectrum. He was non verbal and had developed his own system of gestures. He had been unable to live with his birth family, and had lived in a foster family until safeguarding issues had been raised. He was moved at short notice to sheltered accommodation while a decision was being made about his longer term accommodation.

The IMCA spoke to staff and residents about Sam's capabilities and interests and then met with Sam with photos about different types of accommodation and different services. She offered happy, sad and angry faces for him to place where he wished. She repeated this on a number of occasions and Sam chose consistently. This information was fed back to the social workers.

The IMCA then checked on other aspects of his care plan. She noted there was a reference to a communication book in his notes but there was no sign that this still existed. She asked if this could be put together again. She noted that he had been attending a day service project which had closed and she asked what alternative services could be offered. She found certificates in music in his file and asked whether this interest could be continued in some way.

The IMCA asked about independence training; about whether Sam could be more involved in choosing what he ate and also be more involved in the shopping for his food. She asked for a referral to help him manage his incontinence. And she asked for a referral for communication development.

The outcome was a move to a place that Sam had been involved in choosing, and a care plan that better met his needs.

Where were people staying when the IMCA was instructed

Figure 3.1 shows where the person was staying at the time of the IMCA instruction, where this was recorded. There have been slight changes in the distribution over the last six years. In the first few years of IMCA services, the greater proportion of IMCA instructions were for people staying in hospital. This has changes over the recent years, where the larger proportion of instructions are for those staying in care homes at the time of instruction.

Figure 3.1: Where people were staying at the time of the instruction over the last 5 years

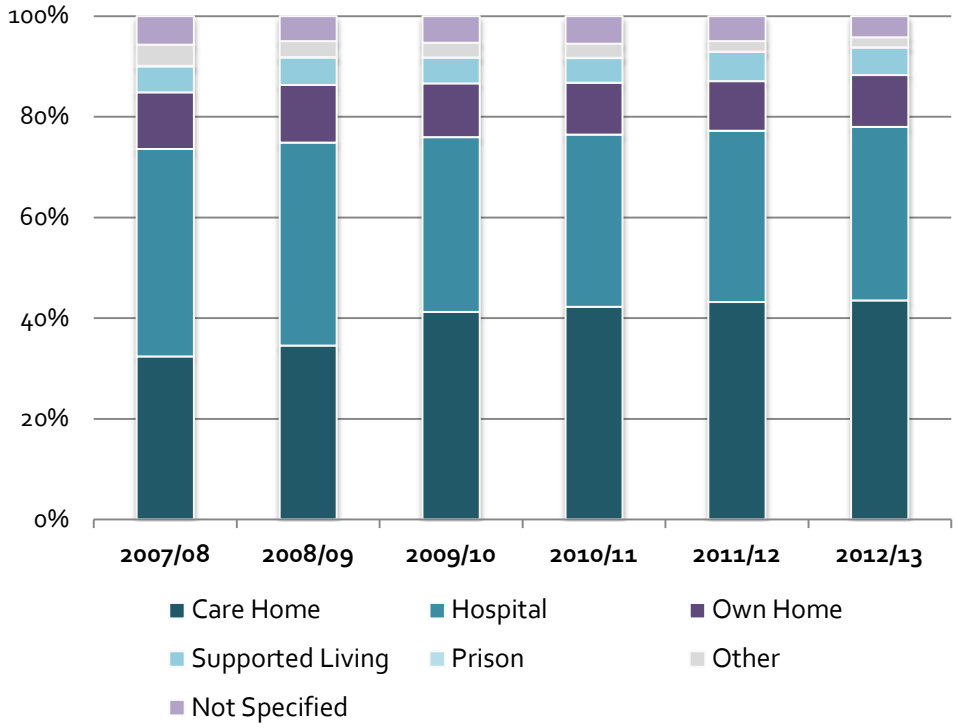


Figure 3.2 shows the largest group of people receiving IMCA support in 2012/13 were staying in a care home – 5,120 people (43%) followed by 4,056 in a hospital (34%).

Around 10% were in their own homes. These figures have remained similar to the proportions in the previous year.

Figure 3.2: Where people were staying for different IMCA instructions

Where staying at time of IMCA instruction	2010/11	2011/12	2012/13	% 2012/13
Care Home	4,574	5,247	5,200	43%
Hospital	3,706	4,127	4,113	34%
Own Home	1,112	1,194	1,237	10%
Supported Living	535	709	660	5%
Prison	4	3	3	0%
Other	301	256	238	2%
Not Specified	597	605	500	4%

Figure 3.3 shows where people were staying or living at the time of instruction, for each type of decision. Around 40% of those receiving IMCA support for safeguarding were in care homes

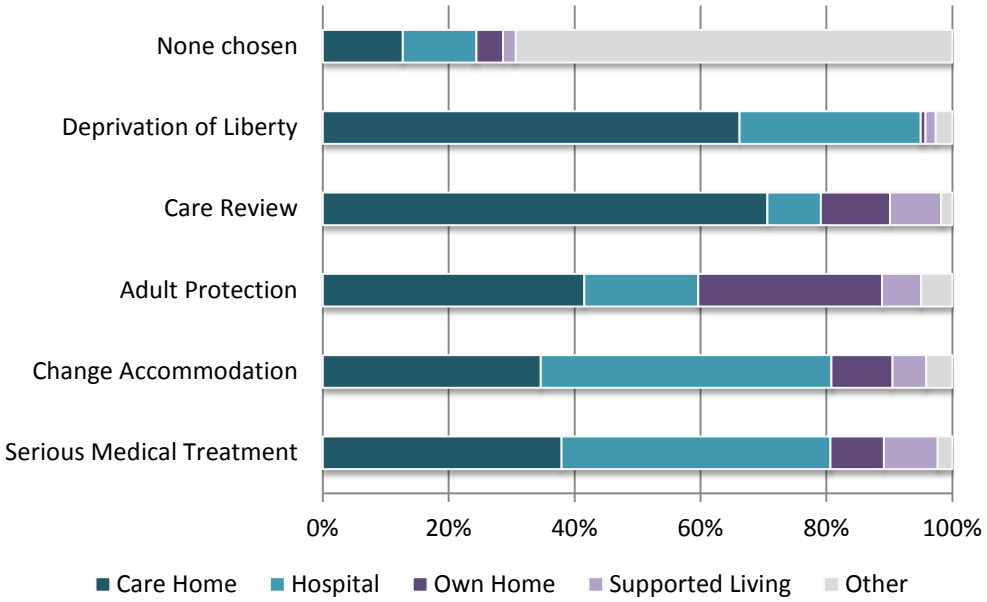
and nearly a third of the safeguarding referrals were for people living in their own homes, in the community.

People receiving IMCA support and representation for care reviews were mainly living in care homes; some 70% were in these settings. Only 10% were in their own homes – which raises questions about whether care reviews in the community may not be perceived as generally requiring an IMCA.

Almost half of the referrals for a change of accommodation were for people in hospitals.

Deprivation of Liberty referrals generally take place for people who need to be deprived of their liberty in care homes/ nursing homes and hospitals. The small numbers in supported living may be people about to be moved into a care home or hospital, or are being referred to the Court of Protection for authorisation.

Figure 3.3: Where people were staying for different IMCA instructions, 2012/13



Where the person was at time of instruction

Mr Jones had been unable to weight bear for the last 12 years. He was living in his own home with a care package of 4 visits a day. After his wife died he was moved to a rehab

unit due to high grade pressure sores and a sacral ulcer. He required assistance with bathing and toileting and refused the use of a hoist. He had requested to return home for the entire time he was there.

An IMCA was instructed with his proposed move to a nursing home. The IMCA met with Mr Jones and they had several long conversations about the options. He consistently maintained that he wanted to go home. The IMCA attended the best interest decision meeting; asked for Mr Jones to be present; challenged the capacity assessment as it appeared to him that Mr Jones did have capacity and was making requests which appeared 'unwise' – ie high risk – to some professionals, but which needed to be listened to.

The meeting was long; it discussed risks and established there was no substantial evidence of risks – for example Mr Jones was happy to wait in bed until two staff came to get him up; Mr Jones had never attempted to get out of bed on his own.

After this best interests meeting, attended by members of the multi-disciplinary team, professionals were able to put together a care plan to support Mr Jones in his home for a trial period of three months. He was coping well at the time of his care review.

Section 4. Serious medical treatment decisions

Serious medical treatment decision - Colostomy

A 67 year old man with dementia had a diagnosis of schizophrenia and cancer of the bowel which was terminal. He lived in an EMI residential home under guardianship under the MHA. He could communicate verbally making his wishes known, but was assessed as lacking capacity to make serious medical treatment decisions.

He had no family and a decision had to be made as to whether surgery took place for a colostomy under a general anaesthetic as part of his palliative care. An IMCA referral was made.

There is a duty to instruct an 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. Serious medical treatment is defined broadly in regulations.

Figure 4.1 records the range and number of serious medical decisions where people received the support of an IMCA.

There were 1,907 referrals to IMCAs for serious medical treatment decisions.

The figures show a 9% increase from the previous year when there were 1743.

Some of the numbers in the categories are surprising, for example the low referrals for IMCAs from cancer wards. Only 127 people with cancer were supported by an IMCA during their decision making in the last year.

Support with decisions about cancer treatment

325,000 people are diagnosed with cancer each year; with one in three of the population being diagnosed with cancer during their lifetime, primarily in older age.

Only 124 people were referred to IMCAs for support and representation for decisions about treatment of cancer during 2012/13.

There were 264 referrals for DNAR and 60 for artificial nutrition and hydration, which are both decisions considered with an elderly population with dementia, towards the end of their lives.

There were 18 referrals for decisions about major amputations.

There were ten referrals for ECT; this has doubled in the last year.

The largest single category was for 'medical investigations'.

Figure 4.1: Serious Medical Treatment Decisions in 2012/13

Serious Medical Treatment	***Number receiving IMCA services***	***% of SMT decisions***
Other	597	31%
Medical Investigations	338	18%
DNAR	264	14%
Serious Dental Work	223	12%
Cancer Treatment	127	7%
Major Surgery	69	4%
Not Specified	65	4%
ANH	60	3%
Affecting Hearing/Sight	46	2%
Hip / Leg Operation	27	1%
Major Amputations	18	1%
ECT	12	1%
Pregnancy Termination	3	0%
Not known	56	2%
Total	**1907**	100%

IMCAs were involved in 264 decisions about DNAR.

IMCAs were involved in 264 decisions about DNAR.

A 76 year old man, had a diagnosis of dementia and was reported to be in the end stages of his life. He resided in a nursing home where he had lived for 8 months. He could communicate verbally but could be difficult to understand, he also had hearing and visual impairments. He had a step son who had been reported to have been manipulating him. The step son had not been in contact with the client since the client has been at the nursing home.

The decision was whether to place a DNAR order on his file.

Section 5. IMCAs and Safeguarding

IMCAs and Safeguarding

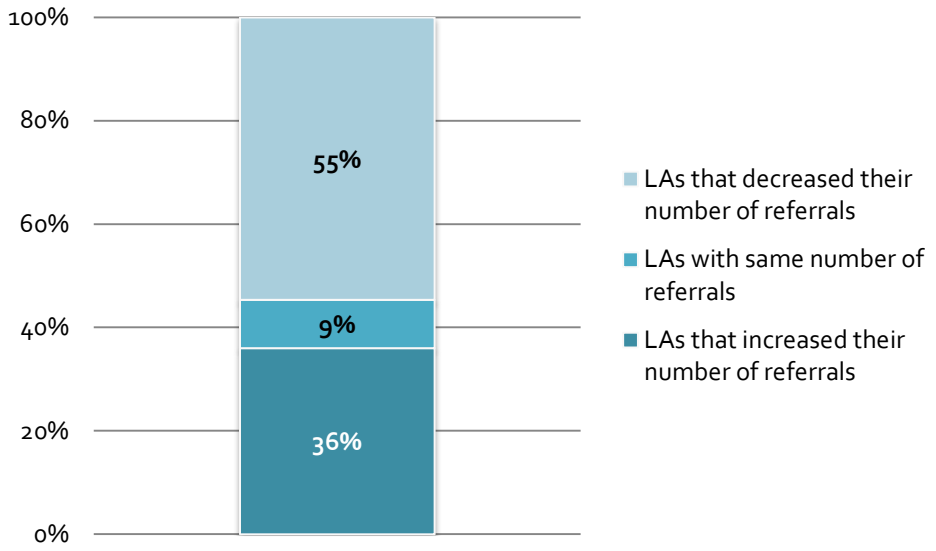
The total number of people benefiting from the support and representation of IMCAs in safeguarding cases was 1482.

This is a decline in each of the last two years - from 1533 in 2011/12 and from 1548 in 2010/11.

There were 82 local authorities that made fewer IMCA referrals for safeguarding in 2012/13 than in the previous year.

Figure 5.1 below shows that 55% of LAs made fewer safeguarding referrals in 2012/13, while 36% increased their referrals.

Figure 5.1: Changes in 2012/13 from 2011/12 of IMCA instructions for safeguarding



Local authorities with the largest increases are shown in figure 5.2 below.

Figure 5.2: Local authorities with the largest increases in IMCA support for Adult Safeguarding [Data extracted 31st October 2013]

Local authority	2011/12	2012/13	Absolute difference from previous year
NORTH SOMERSET	*34*	*85*	*+51*
NOTTINGHAMSHIRE	*4*	*19*	*+15*
LANCASHIRE	*19*	*34*	*+15*
LEEDS	*56*	*70*	*+14*
STOCKTON ON TEES	*6*	*18*	*+12*
BLACKPOOL	*3*	*14*	*+11*
CROYDON	*4*	*15*	*+11*
BRISTOL	*12*	*22*	*+10*
CENTRAL BEDFORDSHIRE	*4*	*13*	*+9*
DERBY	*15*	*24*	*+9*

Local authorities with the largest decreases are shown in figure 5.3 below.

Figure 5.3: Local authorities with the largest decreases in IMCA support for Adult Protection/Safeguarding [Data extracted 31st October 2013]

Local authority	2011/12	2012/13	Absolute difference from previous year
EAST SUSSEX	*54*	*27*	*-27*
HERTFORDSHIRE	*36*	*10*	*-26*
SOLIHULL	*30*	*9*	*-21*
ESSEX	*35*	*14*	*-21*
NORTH YORKSHIRE	*28*	*11*	*-17*
LIVERPOOL	*18*	*4*	*-14*
DERBYSHIRE	*49*	*36*	*-13*
LEICESTERSHIRE	*16*	*4*	*-12*
SANDWELL	*16*	*4*	*-12*
BARKING & DAGENHAM	*15*	*4*	*-11*
LUTON UA	*15*	*4*	*-11*
KENT	*24*	*13*	*-11*
HAMPSHIRE	*26*	*15*	*-11*

Safeguarding

For the second year, there has been a decline nationally in the number of cases where IMCAs have been representing people who were subject to safeguarding.

There were 1,482 safeguarding IMCA referrals, while national safeguarding data collected by local authorities shows there were over 173,000 reported safeguarding alerts in the last year.

This means fewer than 1% of people who were referred to local authorities for safeguarding assistance received the help of an IMCA.

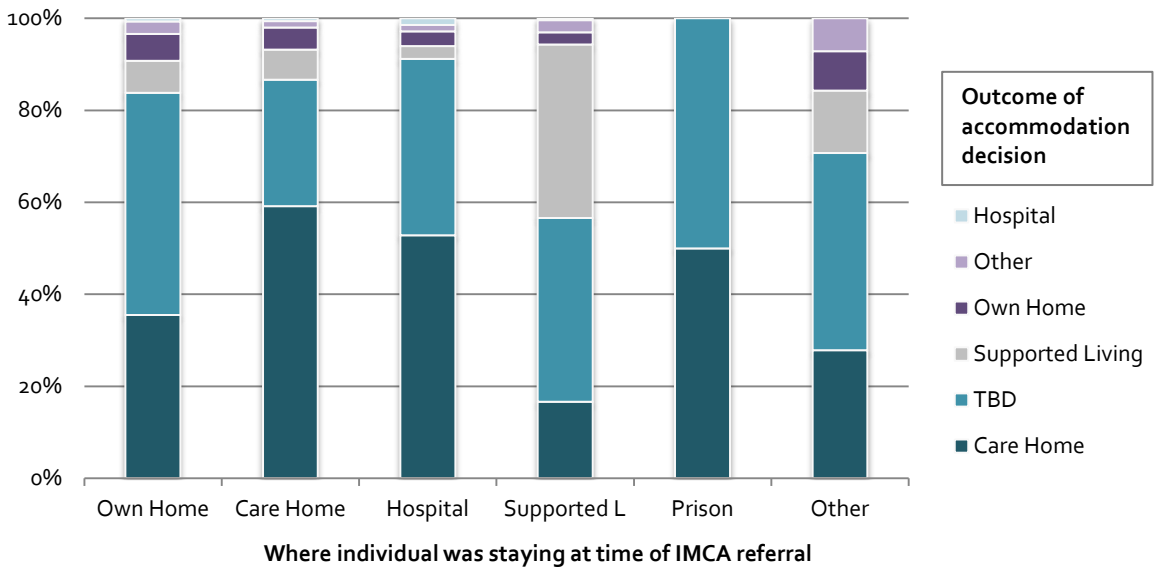
Section 6. The outcomes of the accommodation decisions

Figure 6.1 compares where the person was staying when the IMCA with instructed with the outcome of the accommodation decision where this is known.

The chart shows that a large proportion of the outcomes have been recorded as “To be decided”. This reflects that many IMCAs may not be informed of the final accommodation decision taken, which is poor practice.

Over 50% of those staying in hospital at the time of the IMCA instruction move on to a care home, whilst only 30% of those staying in their own homes at the time of the IMCA instruction move on to a care home.

Figure 6.1: Outcomes of accommodation decisions, 2012/13



IMCAs may have an impact on:

- the type of accommodation,
- the choice of accommodation,
- how well a particular care home will meet a person’s best interests and
- on the support the person receives whether in their own home or in a care home.

All these are important elements of the quality of life of a person facing an accommodation decision.

These four factors can be influenced by IMCAs providing information to the care home provider about the person's history, needs and wishes.

IMCA reports are an important provider of 'life story' information for a person. Having statutory rights to look at information provided in both social care files and NHS files, allows IMCAs to build up a picture of the person's previous experiences and wishes and this is invaluable in developing personalised care in the future. It is possible that there are no further opportunities to put together 'life story' work after a move has taken place.

Box on Life Story

"There are many ways of putting together a life story. If you can get photos they help guide you through the significant events in a person's life – their childhood, whether they got married, had children, what they worked as, what their interests and hobbies were and still are. A life story book is often a bridge between the past and the present, and may tell people that someone was a great gardener and loved plants or was a train enthusiast or loved books or knitting or chess. They may have fought in the war or been a dinner lady and served a million meals. If I can't get photos then I try and get what information I can from the files to use as prompts, and then ask a lot of question – of everyone I can get hold of. I always ask what kind of music they liked, because that is something that can be provided wherever they live. And most importantly, I am amazed what clients themselves tell me, even where they are confused about time and place, they remember so much."

Section 7. The Deprivation of Liberty Safeguards

This report provides data on the fourth year of the IMCA roles in the Deprivation of Liberty Safeguards, as these safeguards began at a later date than the rest of the MCA.

The IMCA role in the Deprivation of Liberty system is particularly important.

IMCAs provide an important legal safeguard, upholding people's human rights – to liberty, to autonomy, to family life and to justice.

They support and represent people during the assessment, so that their voices are heard and they enable the assessment to considers their wishes and feeings. They support and represent people after the assessment, when the deprivation of liberty has been authorised – but where people have the legal right to challenge it in Court. And they support and represent people and the person who is representing them (for example a family member) in the longer term.

In each of these roles, their task is *to represent the person*. In particular to 'familiarise themselves with the person's circumstances'… 'to consider whether they have any concerns about the giving of an authorisation'…'to apply to the Court of Protection' if they have concerns.

The three IMCA roles in the Deprivation of Liberty Safeguards 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. As part of this role IMCAs not only have a power, but an active duty to help people exercise their rights to challenge a detention if that is what they want to do.

Figure 7.1 shows the number of IMCA DOLS referrals broken down across the last four years. It shows that following an increase in each of the last three years, there has now been a drop in the number of IMCA- DOLS referrals in 2012/13 across all three DOL categories.

Figure 7.1 also shows the underlying distribution each year of the three types of DOLs has not changed very much in the last three years. Only the first year's distribution was very different and skewed heavily towards 39A DOLS referrals (over 70%).

Figure 7.2 shows that in 2012/2013, referrals for 39A DOLS made up almost half of all DOLS referrals and are relatively stable over the years.

However the largest decrease has been in 39D referrals, where there has been a decline of 17% in the national figures.

Figure 7.1: IMCA DOLS referrals for the last four years

Type of IMCA DOL	2009/10	2010/11	2011/12	2012/13
39A	893	876	909	880
39C	163	174	156	140
39D	173	627	934	782
Total	**1,229**	**1,677**	**1,999**	**1,802***

*data on type of DOL only available for 1802 cases.

Figure 7.2: Distribution of the type of IMCA DOL referrals over the last four years

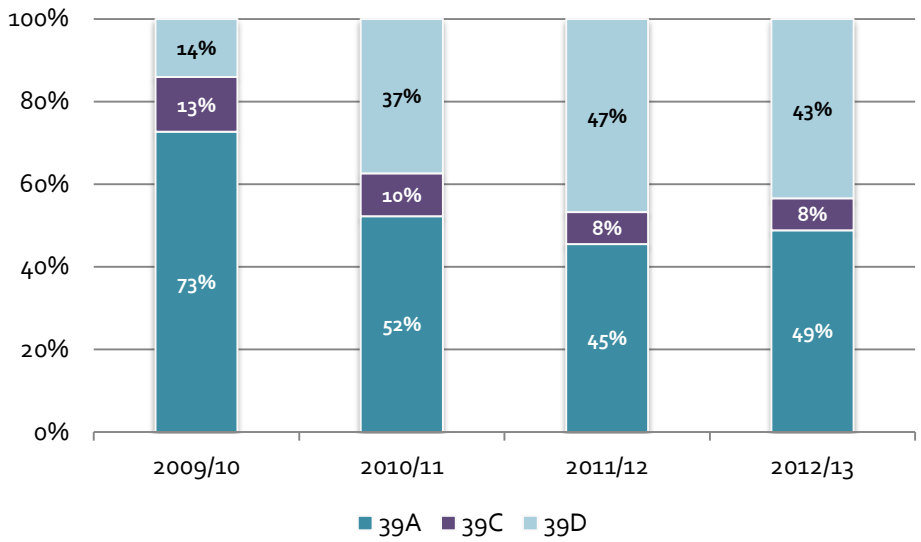
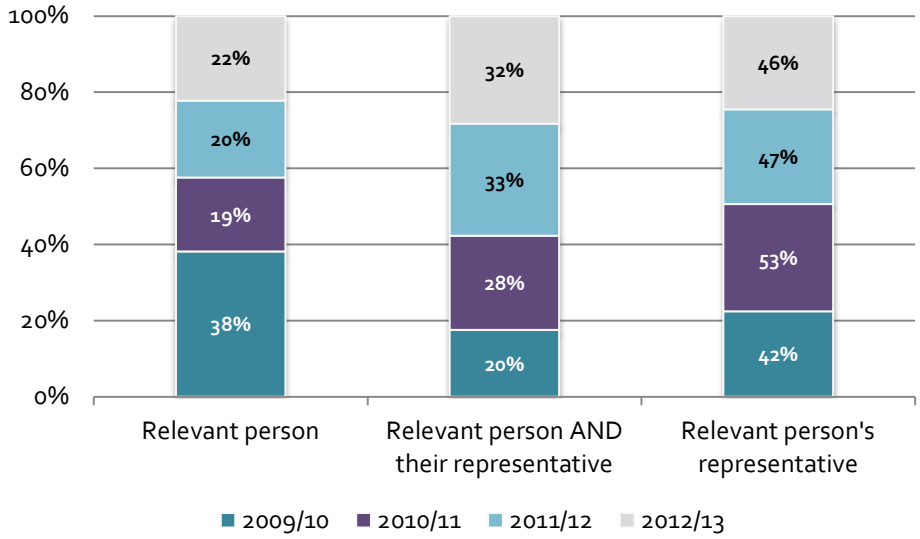


Figure 7.3 shows that the distribution of who 39D IMCAs were requested to support has broadly stayed the same over the last two years. A large proportion (46%) were requested in 2012/13 to provide support for the individual's representative, 32% were requested to support the individual AND their representative, while only 22% were requested to support the individual only, by themselves. This is in contrast to the first year of DOLs referrals, where 38% were requested to support the individual only, and not their representative.

Figure 7.3: Who 39D IMCAs were requested to support



In the past years we related DOLS figures to the statistics published for DOLS activity nationally over the last three years. This showed that the rate of section 39A instructions related to applications for standard authorisations has decreased from 12.5% to 9.7% and then in 2011/12 to 7.8% We were unable to do this analysis this year, due to the missing data on type of DOLS in this year's data.

Both 39C and 39D IMCAs are only available to people who are subject to an authorisation.

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.

This includes the IMCA ensuring that the person and their representative understand that they have the right to have an authorisation reviewed, and they have the right to access the Court of Protection. The decreased use of 39D IMCAs is concerning (Even if all the unallocated DOLS cases were 39D cases, there would still be a decline in the number of 39D IMCA referrals. The table in the appendix shows which local authorities are high and low users of 39D.

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. "*

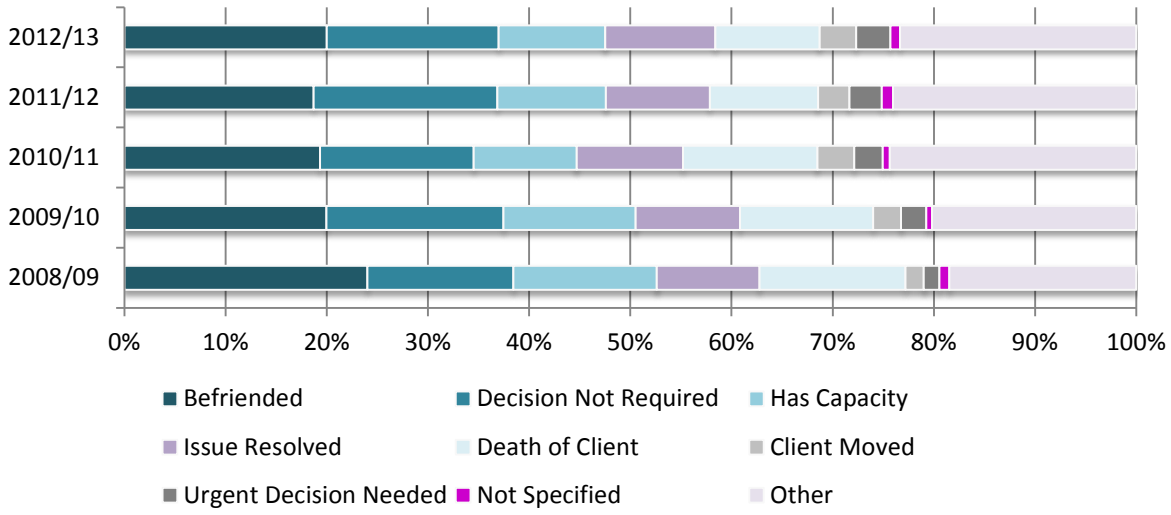
IMCAs can support family members (who are appointed as the relevant person's representative) about the right to challenge the DOL authorisation. They can also negotiate less restrictive conditions to remove the deprivation, they can ask for independent mediation and/ or they can challenge the DOL in the Court of Protection at no cost. These are all important safeguards that IMCAs nee to consider responsibly, for each person they support.

Section 8. 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 just under 60% of the 7,394 eligible instructions which had been marked closed by the time this data was drawn.

Figure 8.1 shows that the primary reasons why IMCA reports were not provided were due to either the individual being befriended or the decision not being required. In recent years, a growing number of referrals where IMCA reports were not provided have given the general reason as “other” rather than the other specified reasons.

Figure 8.1: Reasons why IMCA reports were not provided



Section 9. Reflections of IMCAs

IMCAs take referrals from a wide range of professionals, and a sample of these are listed in Table 9.1. These illustrate both the large numbers of people who need to know about the IMCA service and need to know when and how to make referrals, and also the large number of people that IMCAs need to work with.

Table 9.1 Who made referrals to IMCA services?

Discharge Liaison Nurse	GP	Social Worker	Brain Injury Service
Adult social care	CMHT	Consultant	DOLS team
Specialist Vascular Surgery	Supervisory Body	Access team	Care Manager
Community Team	Children's services	Care home liaison nurse	Onward care team
Psychiatric Liaison	Medical team	Consultant Neuropsychologist	Burns Unit – Consultant Plastic Surgeon
Learning Disability Team	Best Interests Assessors	Neurological Rehab Unit	Mental health Unit
Ward staff	L D Liaison Nurse	No Recourse to Public Funding Team	Hospital Discharge Team
Safeguarding team	Active Intervention Team	Older People's Services	Onward care team
Children's Services	Access Team	Complex case management team	Haematology
Staff nurse	Urban team	Matron	Support Worker
NHS	Commissioning team	Ward Manager	Recovery Team
Dentist	Home Manager	Old People's Mental Health Team	Consultant team Endocrinology
Assessment and Resettlement	Care home staff	Long Term Intervention Team	Psychiatrist
Charge Nurse	Nursing Home Service	Acute stroke unit	Continuing Health Care
Later Life Team	Access and Initial Assessment	Speech and Language therapist	Dementia specialist team
Consultant cardio thoracic	Advanced Nurse Practitioner	Out of Borough Social Work	Multi-Disciplinary Team
OT	Ophthalmologist	Support Planning	Specialist screening
Vulnerable adults team	OP/ PD team	Care services coordinator	Transitions team
Intermediate care team	ICU	Recovery Team	Campus Reprovision Project
Oncology	Complex multiple Impairment Team	Gastroenterology	Resettlement Co-ordinator
Supporting Living Service	Community Matron	Hospital Elderly Assessment Team	Solicitor
LD Forensic Service	Substance Misuse Team	Enablement and Care Team	Independent Advocate

IMCAs are asked to reflect on their cases in the national IMCA database and these were analysed to answer two questions: a) the obstacles to effective IMCA work and b) what made for a good outcome.

Obstacles

Various obstacles were noted. By far the largest obstacle reported by IMCAs was 'lack of good communication' between the people making the referral and the IMCAs responding to the referral. This included not providing information that was

a) *sufficiently early* to enable IMCA support to assist the person to be as involved as possible in the decision making;

b) *sufficiently informed about the decision making* timetable to enable IMCA representation to fit into the decision making processes (and not just be available at the end);

c) and *sufficiently person centred* to enable best interests decision making to be genuinely personalised, with full information on a range of options in relation to the person's wishes and feelings.

IMCAs reported that:

"The lack of contact made it difficult to establish when to make my representations."

"Paperwork was not received in a timely fashion."

"SW seemed to wish to rush the decision through without paying attention to some key elements of the individual's social needs."

"They were very slow and disorganised and many delays were caused .. the result was A was in hospital nearly a year longer than was necessary."

"Social worker was difficult to contact, was not able to provide relevant information, the move was made without involving IMCA, complaint was raised."

"Failure to instruct; IMCA was instructed by care home after the pre-op had already taken place."

"The Consultant was unavailable to consult with - 'he did not do emails'."

A second obstacle was reported in relation *to delays:*

"*A referral for this client should have been made months earlier-before 2 admissions to hospital after which it was difficult to establish his wishes".*

"Referral was made very last minute. They were expecting to move client with only one working day to allow for IMCA involvement."

"Best interests decisions delayed because LA and NHS could not agree who was responsible."

A third obstacle was lack of clarity about who was responsible for the decision to be made'.

In many cases the person did not appear to have an allocated social worker; or the cases were held 'by the discharge team without a named person responsible'; or there were a series of different social workers involved for short periods of time during which the cases was not progressed; or there was lack of clarity, or a dispute- between health and social services.

> *"No medical professional or social services employee was prepared to take leadership in relation to the decision maker role. The elderly client had been waiting to be discharged in a well state for 2 months prior to IMCA involvement".*

A fourth issue reported was lack of honesty with the client:

> *"In the end he was tricked into going to a care home".*
>
> *" The Local Authority removed the option of the client remaining in their current accommodation by terminating the service contract before the best interests decision making process began."*
>
> *"The client was deemed to have capacity yet still was not allowed home – and none of the professionals thought this was dishonest or wrong."*
>
> *"Any decision making which does not try to consider different options is in effect dishonest – as there almost always are different options".*

A fifth issue, raised specifically in relation to safeguarding, was lack of working together. There were a variety of comments which suggested that safeguarding professionals, policies and processes appear unclear about whether an IMCA should be involved in safeguarding – and whether they should stay involved once they receive the initial referral.

> *" The Safeguarding Manager didn't respond to my requests for contact and information; didn't send me Minutes of Best Interest Meetings; didn't inform me when client moved. "*
>
> *" Safeguarding process not followed through or closed as far as I was aware. They didn't tell me that the client had passed from health to social services for management. Didn't respond for months to my requests for info. I am very frustrated that my client has been denied their right to be independently represented and safeguarded and I have been unable to fulfil my role as his IMCA."*
>
> *"Safeguarding in this authority is done to clients – not with them. Clients don't have rights or choices once they are 'in safeguarding'."*

IMCAs self reflections on areas for own improvement

IMCAs were asked to self reflect about their own role – and whether they could have been more effective. The issues they raised were: change of providers; change of IMCAs; size of case-loads; change of contracts; working with families.

The issue raised most frequently in terms of improvement was the uncertainty caused by contracts ending. There were several comments about demoralisation - IMCAs working while their service was being retendered and the tender specifications required cuts.

"It is a short term contract and at the back of your mind you know the LA wants a new provider who is cheaper so you might as well give up and look for another job."

"They want it cheaper – that means each person gets less support and less time. You can't be true to the principle of the MCA if you are being told to spend less and less time with clients. You can do a quick visit – but you can't do proper supported decision making."

IMCAs also reported that 'change of IMCAs' within a referral was an area that was problematic. Whether this was due to staff shortages, sickness, 'too many cases' or change of IMCA provider, IMCAs reported that it was the clients who suffered from the lack of continuity leading to lack of effective support to the client.

Finally some IMCAs reported frustration when working with clients who had families involved. Some IMCAs thought it was inappropriate for IMCAs to be involved if the person had any family at all; others thought they did not want to be 'caught in the middle' if there were disputes between families and professionals. Others however reported that in some cases with the involvement of the IMCA, family were able to resolve differences and to become better involved.

Outcomes

The second area we wanted to explore was what the perceived outcomes were for the clients of IMCA services. These were hugely varied and not easy to classify.

First there were IMCAs who commented that the outcome was that the decision making process itself was improved – that the client's rights had been protected, and that they had been much better involved.

"*Was able to bring the clients wishes to the fore".*

"Client had complex family issues with some family for and some against the decision being made. IMCA's role ensured that client was kept at the centre of decision making process".

"IMCA was able to ensure that the NHSCHC Funding application was processed speedily and an appropriate nursing home found for the client".

"The IMCA service helped empower this young person to speak up for themselves at their care review by helping them prepare for the meeting, prompting etc."

"*Because I had previous involvement over a number of years for different decisions I was able to provide some historical perspective and my involvement was more effective as a consequence - particularly as the decision maker did not have the same history with the person."*

"Social worker made the referral - GP declined to consult and I had to write explaining BI decision making and the GP's statutory responsibilities."

Second, there were consequences for increased liberty or increased autonomy for the client.

"It is becoming more clear what the client's wishes are and with IMCA support he has now had large increases in unsupervised independent activities".

"Raised issue re client wanting to visit potential placements and being prevented from doing so – I raised this with senior hospital staff – and the client was later supported to view options."

"Able to raise significant issues such as likelihood that client would gain capacity - he was recovering from head injury. DOLS was only authorised for a very short time and he was discharged soon after."

"What really mattered to her was being able to see her friends at the bingo. They agreed to arrange this."

"What she wanted was to be able to choose some things in her life. After a lot of discussion it was agreed that the care plan would identify the areas where she could have choices. And they called it the areas where she was "allowed choices."

"He just wanted to go for walks. Once this was recognised and risk assessed – it was agreed.""

Third, there were new issues or new needs which IMCAs had identified.

"Client was very poorly and was visited initially as Change of Accommodation client. But then a Serious Medical Treatment referral was raised by the IMCA during the course of the initial investigation. This led to treatment she would not have otherwise had – as her needs were unnoticed".

"IMCA raised issues re client's finances for social worker to investigate".

"Client moved to placement near family, family became able to be more involved, client able to maintain contact with her pet. This was what she wanted."

"I did not speak to the client as she died quickly, but I was able to check the MCA had been followed and I ensured that her religious beliefs were upheld in her funeral".

"*This client wasn't accessing the community and expressed a wish to do this and to go to church. Through the review process we were able to highlight these issues with the home and ensure a care plan was put in place to address the client's wishes."*

"I organised her and her husband's case to be looked at together. It was amazing what a difference this made."

"IMCA made suggestions for closer contact between client and her disabled husband."

Fourth, there was provision of specialist MCA information/ understanding.

"I gave the decision maker extensive advice including the latest guidance from the Court of Protection about tenancies for those who lack capacity."

“I attended multidisciplinary best interest meeting and explained Article 8 rights to participants in the meeting. It made them re-think the options.”

“ I advised that the BI decision preventing her from returning home to live with her husband who wants her home could amount to breach of article 8 requiring application to CoP / urgent DoL. Advised further mediation / negotiation in hope of finding a way forward, and for the hospital to consider getting legal advice.

“*Referral was for a DNAR Review but led to the Decision Maker agreeing that the original DNAR (by another Doctor) did not comply with MCA requirements. DNAR Order was cancelled at the review.”*

“*If investigations and treatment (covert administration of meds as patient was refusing) for Pulmonary Oedema had not gone ahead patient would have suffered a painful & undignified death, treatment went ahead and patient is making good progress.”*

“DOL period of authorisation reduced by Supervisory Body following IMCA's representations.”

“I sometimes challenge with a referral to the Court of Protection. But in this case it was enough to say that I would make a referral to the Court and they backed down.”

Fifth , there were <u>outcomes which the IMCAs considered they had contributed to in a major way.</u>

“I achieved a good outcome for the client - especially considering she was 105, I argued strongly for the least restrictive option and it was discussed and I managed to secure funding for her to stay here, where she appeared happy and settle. Therefore she didn’t have to endure the upheaval of moving.”

“Deprivation of liberty was granted but with good support and conditions to minimise effects.”

“Initially this was put as a decision about where to move him to. But then with IMCA involvement it changed - away from an accommodation decision to how to help support them at home, with an increase in staff support to monitor and manage the challenging behaviour.”

“IMCA requested new capacity assessment changing the entire outcome for the client.”

“IMCA traced family member who is closely involved. “

“Was able to locate his sister who had lost contact some time before.”

“IMCA challenged the standard of care vigorously”.

“Able to represent gentleman during POVA process and ensure he did not move as a result of the issues in the home.”

"IMCA helped family to realise they could have client home once they accepted the necessary care package."

"My suggestion of the introduction of a support worker allowed the client to remain in the care home where she was content and settled(rather than have to move to EMI care home)."

"I argued for family mediation – and eventually they agreed. It worked."

Finally IMCAs' commented on their role, which were varied but overwhelmingly positive.

IMCAs said they often worked with 'social workers who went the extra mile' –and they worked closely together in these cases to uphold the rights of the clients. IMCAs remarked that some doctors – for example in neurology – had a strong understanding of the MCA. But they sometimes worked with professionals who had very little understanding of the MCA and then IMCAs had a more urgent and more difficult role. They often challenged within the decision making process, without needing to formally refer a case to Court.

IMCAs reported that they always advocated for a person's wishes and feelings; they also often advocated for least restrictive options. They were mainly very clear that empowerment is at the heart of the IMCA role – and should be at the heart of social care decision making. They often wanted to offer more support for client decision making, than time permitted. They reflected "*This client would have been very vulnerable without IMCA representation,"* – the combination of mental impairment, the perceived lack of decision making capacity and the professionals making decisions without the person being involved led to many people being in situations which made them very vulnerable.

Many reported they were frustrated by the lack of available options for people who need considerable support but wished to continue living in their own homes. Many IMCAs would and did recognise a Deprivation of Liberty – and some were thinking more broadly about the need for *planning for liberty within all care plans*. IMCAs were often proud of the speed with which they responded*: I acted within 2 hours on their instructions and attended emergency meeting that afternoon.* Many were experts on using the Mental Capacity Act and kept up-to-date with case law. Increasing numbers have the experience and the confidence to take cases to the Court of Protection. Most IMCAs were very aware of the their specialist expertise as 'MCA champions', and of the weight of their responsibilities: "*She had literally no-one in the world apart from support staff* ".

Section 10. Court of Protection

The Court of Protection during 2012/13 continued to hear many Best Interests and Deprivation of Liberty cases. The Department of Health and Court of Protection judges continue to encourage local authorities and the NHS to refer cases to the Court where there are significant disagreements about what is in a person's best interests, and about what may constitute a Deprivation of Liberty. The Department of Health guidance issued in 2010 still holds: cases involving significant interference in family relationships (ie restrictions on contact with family) should be referred to the Court and not dealt with under the LA authorised DOLS system.

The NHS referred many cases to the Court, for example, involving anorexia and forced feeding, forced feeding under the Mental Health Act as well as disputes about end of life care decisions, including Do Not Attempt Resuscitation (DNAR) decisions. Local authorities referred cases about restrictions, restraint and deprivation in care home settings as well as best interests decisions about where a person should live and cases involving 'protection plans' under safeguarding.

IMCAs have been increasingly asked to be litigation friends, and some have done so. They mostly report that it is time consuming, and that they are not funded to undertake this role; but that where a person has no one else and the Court requests them to be the litigation friend, then they can and will do so. We do not have statistics to be able to quantify the numbers.

There continue to be several cases where judges speak directly to those who had been assessed as lacking capacity to make the relevant decision.

The Court continues to publish many of its significant judgements, and these are of huge importance to all those working with people who may lack capacity. While the judgements are about specific cases and specific people, judges also illustrate how to weigh up questions of protection with autonomy, how to create a 'balance sheet' of issues before making a final decision; how to weigh happiness as well as risks.

The case of DE and a NHS Trust
(http://www.bailii.org/ew/cases/EWHC/Fam/2013/2562.html)

In this report we choose to draw attention to one Court of Protection case, one that has particular implications for the work of both IMCAs and local authorities. This is the case of DE - where the Court was asked to make a best interests decision with implications for a man's sexual relationship.

This case is the first time that a court in this country has made an order permitting the sterilisation of a man who was unable to consent to this, for non-therapeutic reasons. However the reason that this case is summarised here is not because of the sterilisation, but because of the reasoning that led to the application to Court.

DE was aged 37 and had learning disabilities. He lived with his parents who had worked hard to help him to attain a degree of autonomy, which led to him travelling independently on the bus, attending a day centre independently, going for walks in the centre of town with a friend, participating in two swimming clubs, and having a long standing and close relationship with a girlfriend, with whom he had a sexual relationship.

When DE's girlfriend became pregnant and gave birth to a child, this led to safeguarding intervention, and protective measures put in place to stop this happening again. The judge described this as *'DE's life was turned upside down'.* The protective measures included stopping DE and his girlfriend being alone together and stopping them visiting each other's homes. The protective measures led eventually to the end of their relationship. It also led to DE becoming supervised at all times.

The impact of the protection plan was summarised as:

DE experiencing the loss of engaging with the community without supervision/staff support;
the loss of being able to walk through town from one venue to another with a friend;
the loss of the ability to go alone to shops, making purchases, interacting with traders and passers-by and the loss of the use of the local gym and facilities on the same terms as any other participant.

And the loss of privacy, the loss of a long term relationship, the loss of autonomy.

The Court heard how this led to a marked adverse impact upon DE, how gradually his ability to go out and do things was lost, and he suffered what was described as a loss of confidence and fear of doing wrong.

The Court then heard from a psychologist that *DE 'might be able to attain capacity to enter into sexual relations if the right sort of direct work was done with him'*. The case was adjourned so that the psychologist and the LD nurse could work with DE to assist him to acquire capacity to enter into sexual relations. Fourteen one hour sessions followed and DE was then judged to have the capacity to enter into sexual relations. He resumed his relationship with his girlfriend and regained much of his former liberty to engage with the community alone or with friends.

This case is important because it shows :
- the huge difference in quality of life for the same person when assessed as lacking capacity and when assessed as having capacity;
- it shows how important it is for public bodies to invest time and money in maximising a person's capacity;
- it shows the importance of recognising and valuing autonomy and liberty,
- it reminds us that relationships should be cherished, supported and valued.

This has implications for IMCAs, local authorities and the NHS.

It is a reminder of Principle 2 in the MCA, that '*A person is not to be treated as unable to make a decision unless all practicable steps to help him to do have been taken without success.'*

As a result,

a) The expectation is that IMCAs seek evidence of 'all practicable steps taken' and the above case demonstrates what some of these steps might involve.

It is a reminder of principle 5, that before someone makes a care plan or a protection plan, they should question whether they could do something else which that would interfere less with the person's basic rights and freedoms. As a result

b) The expectation is that IMCAs have a role in scrutinising care plans and protection plans, to ensure that they are as 'least restrictive' as possible. Again the above case shows how such scrutiny can fundamentally change the quality of a person's life.

Section 11. Commissioning Arrangements

In this chapter we address five commissioning issues which have become important over the last year:

1. MCA awareness raising and the role of the IMCA.
2. Communication and partnership working
3. IMCAs as litigation friends .
4. The role of IMCAs in quality assurance of services for people with mental impairments.
5. The quality of the IMCA service

11. 1 MCA Awareness raising

There is widespread agreement in the evidence submitted to the House of Lords committee on the MCA, that there is not enough awareness and understanding of the MCA, both amongst front line staff and also among service users and their families. The House of Lords has heard evidence of 'widespread non-compliance', of staff not using the MCA when it should be used. This points to the continuing need for awareness raising and training.

In relation to IMCAs:

> The Mental Capacity Act states:
>
> 35
> (1)The appropriate authority must make such arrangements as it considers reasonable to enable persons ("independent mental capacity advocates") to be available to represent and support persons to whom acts or decisions proposed under sections 37, 38 and 39 relate.
>
> 39
>
> (4) …… the local authority must instruct an independent mental capacity advocate to represent P …

Section 39 (4) states that the local authority 'must instruct' an IMCA when certain criteria are met; this requires front line staff understanding when and how to instruct an IMCA. A subsequent section applies to the NHS. These duties apply to front line social work staff, care managers, support workers and others; it applies to staff working in the community, in care homes, nursing homes and hospitals; it applies to health staff – nurses and doctors and other

health service staff. The duty to instruct applies for 16 year olds with learning disabilities in children's homes, to 99 year olds with dementia in end of life care, to people in privately provided learning disability hospitals, to people in brain injury units, neurological wards, accident and emergency departments, renal units and many more.

The local authority needs to decide whether they wish their IMCA service to play a role in this awareness raising and training, to help staff understand when and how to use the MCA. There is no legal requirement for the local authority to include awareness raising in the IMCA contract. However many do. They do because referrals are more likely to follow if staff meet the IMCA service and have the opportunity to ask questions. They do because it helps the local authority and the NHS to be more compliant with the Act.

If a local authority wishes to commission this awareness raising then this needs to be identified in the IMCA contract, for example as a number of awareness raising sessions per quarter or per year. The location of the awareness raising is best determined by the local authority MCA lead and the IMCA service working together to identify where the gaps in referrals – and the gaps in compliance with the Act are.

11. 2 Communication and partnership working

The year 2013 saw an organisation providing IMCA services go into receivership. IMCA staff and IMCA commissioners were given 24 hour notice and local authority commissioners had to make alternative arrangements urgently for people to be able to continue to receive the IMCA services they were entitled to. In this case the local authority was able to make immediate emergency arrangements for cover with a neighbouring IMCA organisation and the service continued.

A key lesson learnt, for the local authority, was the importance of regular communication and having a good relationship with the commissioned service. The commissioner reflected that if they had known about the difficulties earlier, they might have been able to offer some help. In this case they had to do a huge amount of work to ensure continuity of service in a very uncertain situation, and they would work hard to ensure this did not happen again.

Regular meetings between the IMCA service and commissioners and / or the local authority MCA lead were thought to be the best way forward.

The length of contracts also emerged as an issue during 2013. IMCA services are retendered at various intervals and this often means a change of provider. One issue for health and social care staff is that each change meant staff in the whole local authority and the local NHS having

to learn new telephone numbers, new referral routes, new provider policies. This may be an argument for longer contracts.

Similarly, one IMCA service described it as

"*It is a 3 year contract. In the first year all the health and social care staff doing the referrals have to get used to our new telephone number and a new referral form and referrals often decrease while we wait for referrals which do not come. People lose out, and technically the local authority is not compliant with the Act. In year 2 we work well and become embedded. Then the local authority thinks it needs to reduce the budget and it goes for a cheaper service. Cheaper means less time with people and that means less quality. And the cycle starts again.*"

One local authority has responded to this problem, by issuing a five year IMCA contract, which allows the benefits of stability and continuity, while still allowing the local authority to require efficiencies.

11.3 IMCAs as litigation friends .

A) The RPR (Including IMCAs acting as RPRs) can apply under s 21 A to challenge a DOL authorisation; they do not require permission from the Court to apply and their application for legal aid is not means tested.

B) Alternatively RPRs (including IMCAs) can apply on behalf of an adult (P) and the Court will appoint P as party to the proceedings. P must have a litigation friend if P is party to proceedings (Rule 141 of the Cop Rules.)

The Code of Practice is clear that IMCAs can be expected to refer cases to the Court of Protection for the Court to make a determination on Best Interests or on a Deprivation of Liberty. Indeed it is one of the duties of IMCAs to consider in what cases access to human rights, and to justice might require the involvement of the Court of Protection.

The Code of Practice is silent about MCAs as Litigation Friends. Following the Official Solicitor's clarification of his position as 'litigation friend of last resort' , there has been some discussion as to who can or should be a litigation friend for those people who have no family or friends able to do so. The judgement in AB v LCC provides that a RPR can be P's litigation friend if various conditions are met.

There have now been several cases where a Judge in the Court of Protection has directly asked an IMCA to be a litigation friend for a person they had supported. The expectation has been that the IMCA has to have, and to give, serious reasons to the Court if they wished to decline the role of litigation friend.

IMCAs have mainly risen to the challenge and have accepted the role. They have done so to the satisfaction of the Court and without any significant problems. They have become litigation friends in order to ensure that people who lack capacity as well as family have access to the Courts and to justice.

Best practice in commissioning has involved:

a) local authorities setting aside a resource pot for the role of litigation friend, which can be drawn on when necessary;
b) local authorities indemnifying the IMCA organisation for reasonable costs incurred in the course of the Court proceedings. For example where the Court commissions a specialist independent report, the costs of these are picked up by the local authority, in the same way as if they had taken the case to court themselves.

If the Courts are increasingly requiring the role of the Litigation Friend to be carried out by IMCAs, then this needs to be recognised within commissioning contracts.

The Department of Health is commissioning guidance on the role of Litigation Friend.

11.4 The role of IMCAs in quality assurance of services for people with mental impairments.

ADASS Evidence to House of Lords MCA Committee

"We commission a number of services that are there to help quality control what we are doing.. this includes IMCAs… We expect healthy challenge and healthy feedback…that should be helpful. It is part of the quality control of our Department".

Local authorities and the NHS are seeking various ways of quality assuring their work and seeking to identify the 'patient experience' and the 'service user experience' .

The public sector often uses patient surveys, service user surveys, questionnaires and interviews. They commission internal or external audits; they carry out case file audits and they review services and care plans.

They need to pay particular attention to quality assurance for those clients who may lack capacity to make significant decisions. These are the clients least likely to be able to take part in surveys or questionnaires, and least likely to be able to complain, raise concerns or protect themselves.

Quality assuring services for those with severe dementia or significant learning disabilities or brain injuries requires careful thought, and may well require the use of people with specialist skills in communicating, people who are independent of the local authority or the Trust, yet who are familiar with it and already work with it.

Several local authorities are looking at how to use IMCAs as part of their quality assurance for people who lack the capacity to comment directly on the services they receive. This too may be identified as a separate part of the contract with the IMCA service.

11.5 Quality of the IMCA service

ADASS Evidence to House of Lords MCA Committee

"We re-tendered the IMCA service recently….quality was important .. To some extent the quality of the provision is *how many times they have challenged us*.. We look forward to them raising things we can address…. we work in partnership and we value their role".

Commissioners usually wish to include 'quality' in their contracts with the IMCA service. There are a variety of ways that commissioners currently do this.

Quality commissioning may require:

- As much attention to the on-going monitoring of service provision, take-up and performance as to the awarding of contracts.
- Sufficient weighting to quality relative to price in the awarding of contracts.
- Recognition that whilst providers should maximise time spent working with and on behalf of clients, a proportion of resources should be devoted to other activities in order to provide quality services, including CPD, supervision and where appropriate training of referrers and decision-makers by the IMCA provider.

Provider attributes and specification requirements

Communication and working effectively with people who use IMCA services

- Understanding of the impact of various conditions on the needs of different people using the IMCA service (including people with autism, people with profound and multiple learning disabilities/ people with severe and ensuring mental health needs, acquired brain injury).
- Track record and continuing proof of effective training, development and access to internal expertise on understanding the needs of and communicating with people with people with profound and/or multiple disabilities.

Systems for continuous professional development

- Systems for sharing good practice and for cascading learning, including relevant policy and, especially in relation to DOLS, case law updates.

- Contract allowing for and provider ensures sufficient time and adequate arrangements for staff training and supervision and CPD.

Quality of reporting

- Anonymised samples of IMCA reports to be tested as part of tender process.

- Adequate quality assurance systems to sample and test quality of reports.

Enabling duty to refer to be met

- Providers should have a proven track record of working effectively with others to generate referrals to the IMCA service, across the range of IMCA related decisions. This track record assist the local authority and the NHS to be complaint with the MCA.

- Contracts allow for adequate resources for awareness and competence raising of referrers and decision-makers by the IMCA service and for the other related activities highlighted by the SCIE IMCA commissioning guidance.

- The specification avoids unnecessary obstacles to decision-makers making referrals, i.e. gate-keeping arrangements.

Independence

- Proof of approach in challenging decisions informally and formally and of escalating appropriately.

- Contract deals with resources in relation to Court of Protection work.

Safeguarding

- Evidence of management of safeguarding issues including complex ones

- In depth probing on practice at interview

Quality Assurance

- Robust systems for client/ casework review

- IMCA specific component of Quality Performance Mark.

- IMCAs contributing to LA quality assurance systems

Quantity

. Contracts setting targets for the number of eligible referrals and providing incentives for reaching. Incentivising providers. Pay by the hour or pay by the ‘case’ arrangements mean that providers have to take all the risk on people not being referred and may cause an over-focus on existing referral routes rather than ensuring these come from all the areas required.

- Contracts setting targets in relation to positive feedback from referrers/ decision-makers.

Section 12. Conclusions and Recommendations

a. Overall Conclusions

During the sixth year of the IMCA service, in 2012-2013, there were a total of 12,381 eligible instructions for the IMCA service in England. This is a 4% increase from the previous year.

1. It is recommended that commissioners recognise that the number of people statutorily eligible for the IMCA service continues to increase on a year-by-year basis, and that they reflect on the issues raised in Chapter 11.

b. Accommodation decisions

The Mental Capacity Act refers to 'accommodation' decisions when it requires IMCAs to be involved in decisions by local authorities on whether or not people who lack capacity should be placed in residential care – or whether they can and should be supported in the community. There were 5353 accommodation decisions involving IMCAs in 2012-13, which is an increase of 9%.

The Court of Protection continues to require local authorities (i) to seek and consider the wishes and feelings of people who are subject to accommodation decisions, and (ii) to seek decisions which are 'less restrictive of the person's rights and freedom of action'.

2. It is recommended that local authorities and IMCA organisations both carry out self audits of recent accommodation moves, and ensure these two factors (above) are fully reflected in all decisions.

Many IMCA organisations are already alert to possible deprivation of liberty at the point when accommodation decisions and care plans are being made.

3. It is recommended that both IMCA organisations and local authorities continue to be alert to possible Deprivations of Liberty (DoL). IMCA organisations should alert local authorities and the NHS for the need either to prevent a DoL by changing the care plan, or to apply the DoL safeguards, if the person is in a care home or hospital. If the possible DOL is the result of a care package in the community, a referral to the Court of Protection is required. One practical way of addressing this, is to introduce the heading 'liberty' into all care plans, to assist staff to consider ways of promoting liberty as part of care planning.

c. Reviews

Local authorities are expected to carry our regular reviews of accommodation decisions and care plans. Local authorities are expected to involve IMCAs where there are no other family or friends to consult and where the person would benefit from the involvement of an IMCA. DH guidance states that people who lack capacity should have more frequent reviews than others. The Winterbourne Action plan also identifies those who are placed out of Borough as more vulnerable.

4. It is recommended that local authorities carry out a small audit of recent reviews to establish whether all those who would benefit from IMCAs in their reviews did receive one.

d. Serious medical treatment decisions

Hospitals continue to increase the number of referrals for IMCA support and representation for serious medical treatment decisions for people who lack capacity. Referrals increased by 9% last year and reached 1907 cases.

5. It is recommended that Mental Capacity Act leads in CCGs monitor and report compliance with the requirement for referrals to IMCAs for each of their providers, as part of their MCA responsibilities.

e. Safeguarding

Nationally, the number of safeguarding cases continue to increase while the number of these receiving IMCA support and representation for safeguarding continues to decrease. Only 1,482 of 112,000 people receive an IMCA.

6. It is recommended that local authority safeguarding coordinators consider the statistics in this report and report to their Safeguarding Adults Boards on whether safeguarding cases are receiving IMCA support where appropriate..

The Court of Protection case described in Chapter 10 has important lessons about how to build safeguarding practice on the MCA principles, for those who may lack capacity to make decisions on their safeguarding plans.

7. It is recommended that supported decision making is adopted more widely within safeguarding practice, to assist more people to make their own decisions about their safeguarding plans. And before a care plan or a protection plan is made, the question should always be asked about whether any safeguarding action which would interfere less with a person's basic rights and freedoms may be possible.

f. Deprivation of Liberty Safeguards

There has been a decrease of 3% over the last year, of referrals to IMCAs for people who are being assessed for the DOL safeguards or have been authorised as deprived of their liberty. Nearly two thousand referrals were made.

8. It is recommended that IMCAs and commissioners audit a sample of IMCA reports, possibly using the tool designed by Empowerment Matters, reproduced here (with permission) on pages 68 and 69.

9. It is recommended that IMCAs continue to follow Court of Protection advice in published judgements on identifying a possible DOL and on applying the MCA principles in relation to all care planning.

Tables by local authorities

Table A1: IMCA Instructions by local authority 1st April 2012 - 31st March 2013

[Data was extracted on 31st October 2013. The totals differ slightly from tables based on August 2013 data. This is due to the IMCA database where providers can update their data throughout the year. This table is the latest available data.]

Local Authority	IMCA Instruction Type						
	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty	None chosen	Total
Barking & Dagenham	3	11	4	7	1	1	27
Barnet	5	39	7	7	15		73
Barnsley	2	4	1	1	1	4	13
Bath & North East Somerset	7	27	1	9	12	9	65
Bedford Borough	11	15	18	6	13	4	67
Bexley	2	8	3		1		14
Birmingham	41	157	42	13	38		291
Blackburn With Darwen	1	26	10	8	16		61
Blackpool	12	16	14	20	10		72
Bolton	2	8			9	38	57
Bournemouth	7	47	7	8	49	2	120
Bracknell Forest	1	11	3	7	1	1	24
Bradford	24	23	12	5	30	2	96
Brent	1	33	3	3	4	2	46
Brighton & Hove	30	42	14	8	2	1	97
Bristol	68	82	22	28	75	5	280
Bromley	11	30	2		3		46
Buckinghamshire	4	19	6	4	3	4	40
Bury	4	11	6	2	4		27
Calderdale	6	10	2				18
Cambridgeshire	19	60	16	2	21	2	120
Camden	41	86	15	10	28	7	187
Central Bedfordshire	1	8	13	1	1		24
Cheshire	20	45	18	6	20	5	114
Cornwall	35	78	30	19	29	5	196
Coventry	15	54	19	9	9	1	107
Croydon	14	41	15	3	8	2	83
Cumbria	19	41	17	16	7	7	107
Derby	21	46	24	42	9	4	146
Derbyshire	32	88	36	66	69	4	295
Devon	26	81	22	15	17	2	163
Doncaster	6	33	7	2	10	1	59
Dorset	15	40	9	12	40	3	119
Dudley	14	32	11	5	16	4	82
Durham	..				..		2
Ealing	2	13	1	2		1	19
East Riding Of Yorkshire	2	32	5	3	1		43
East Sussex	50	74	27	14	10	3	178

Tables by local authorities

Local Authority	IMCA Instruction Type						
	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty	None chosen	Total
Enfield	9	48	21	1	6		85
Essex	28	48	14	12	68	4	174
Gateshead	6	12	7	6	5		36
Gloucestershire	16	107	24	24	28	3	202
Greenwich	8	21		6	1		36
Hackney	4	34	9	2	16		65
Halton	10	11	6		1	3	31
Hammersmith & Fulham	5	16	1		3	1	26
Hampshire	22	60	15	8	29	3	137
Haringey	6	17	5	3	6		37
Harrow		25	2	1	1	1	30
Hartlepool	1	14	4		1	7	27
Havering	3	21		5	3		32
Herefordshire		11	2	4	15		32
Hertfordshire	10	27	10	7	36	15	105
Hillingdon	3	31	2	3	1	4	44
Hounslow	1	18	1	1	5	3	29
Isle Of Wight	2	6	5	1	4	4	22
Islington	15	32	7	5	12		71
Kensington & Chelsea	4	19	5	3	2	2	35
Kent	74	120	13	27	21	4	259
Kingston Upon Hull	4	16	2	1			23
Kingston Upon Thames	6	30	5		1	4	46
Kirklees	14	35	23	11	9	7	99
Knowsley	16	16	12	3		2	49
Lambeth	14	46	4	4	13	3	84
Lancashire	27	73	34	42	71		247
Leeds	74	177	70	97	36	4	458
Leicester	22	69	10	11	22	2	136
Leicestershire	12	26	4	10	31		83
Lewisham	2	29	4	4	1	1	41
Lincolnshire	15	49	10	1	38	6	119
Liverpool	50	36	4	5	16	15	126
Luton	5	21	4	5	4		39
Manchester	20	110	11	6	57	1	205
Medway Towns	4	10			1		15
Merton		11	3		1		15
Middlesbrough	11	23	9		8	13	64
Milton Keynes	1	3	1	2			7
Newcastle Upon Tyne	19	48	11	7	7	3	95
Newham	3	25	3	8	9	2	50
Norfolk	16	79	8	5	7	2	117
North East Lincolnshire	3	21	7	10	1		42
North Lincolnshire	7	24	2	16	6	1	56
North Somerset	24	56	85	27	29	6	227
North Tyneside	4	23	6	2		1	36

Local Authority	IMCA Instruction Type						
	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty	None chosen	Total
North Yorkshire	5	76	11	12	8	1	113
Northamptonshire	11	51	8	19	10	1	100
Northumberland	14	18	8	8			48
Nottingham	27	79	15	22	14	1	158
Nottinghamshire	25	72	19	27	22	3	168
Oldham	5	14	11	3	8		41
Oxfordshire		42	2	1	45		90
Peterborough	2	20	4	4	5	2	37
Plymouth	15	62	7	12	10	1	107
Poole	4	20	3	7	12		46
Portsmouth	15	34	1		11	2	63
Reading		14	3	5	4		26
Redbridge	3	11	3	3		2	22
Redcar & Cleveland		6	11		2	6	25
Richmond Upon Thames		17	10		1	10	38
Rochdale	3	26	20	2	1	25	77
Rotherham	4	23	6	2	8	1	44
Rutland	1	6			3		10
Salford	8	6		3	1	28	46
Sandwell	16	18	4	2	4	1	45
Sefton	4	25	7	6	3	9	54
Sheffield	27	76	13	10	42	1	169
Shropshire	5	31	6	8	7	1	58
Slough		17	3	1	5		26
Solihull	7	22	9	5			43
Somerset	29	50	11	37	30	3	160
South Gloucestershire	17	30	5	11	23		86
South Tyneside	15	12	11	2	6		46
Southampton	10	30	12	5	10	1	68
Southend	1	11	8	2	3		25
Southwark	4	22	4	7	13	2	52
St Helens	8	10	3	7	4		32
Staffordshire	21	19	7	1	21	6	75
Stockport	14	18	2	2	1		37
Stockton On Tees	7	20	18		3	30	78
Stoke-On-Trent	8	10	2		9	1	30
Suffolk	20	90	10	12	18	10	160
Sunderland	16	27	2	4	7		56
Surrey	62	88	4	11	9	11	185
Sutton	4	9	3	2			18
Swindon	15	29	12	8	11		75
Tameside	4	13	3	4	2		26
Telford & Wrekin	1	15	2	1	5	1	25
Thurrock		10	4	4	7		25
Torbay	12	31	18	9	10		80
Tower Hamlets	10	35	5	2	7	2	61

Tables by local authorities

Local Authority	IMCA Instruction Type						
	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty	None chosen	Total
Trafford	1	9	1			6	17
Wakefield	20	31	18	11	10	28	118
Walsall	8	21	6	4	1	1	41
Waltham Forest	5	38	10	12	8		73
Wandsworth	12	37	14		5	3	71
Warrington	24	15	9	5	10	1	64
Warwickshire	16	39	9	3	7	2	76
West Berkshire	5	24	4	5	1	1	40
West Sussex	24	68	13	14	25	9	153
Westminster	7	24		2	7	3	43
Wigan	22	57	7	14	63	3	166
Wiltshire	13	33	12	3	8	3	72
Windsor & Maidenhead	1	9	7	7	8		32
Wirral	9	43	11	6	12	21	102
Wokingham	4	10		4	2	1	21
Wolverhampton	2	19	10	3	16	1	51
Worcestershire	13	42	11	7	38	1	112
York	12	38	6	10	7		73
Total	1,851	5,147	1,425	1,162	1,869	497	11,951

.. Values have been suppressed in cells where they presented a risk of disclosing sensitive information about individuals

Table A2: The number of DoLS IMCA referrals by local authority from 1st April 2012 to 31st March 2013

[Data for this table was extracted on 23rd October 2013. The totals may differ slightly from data extracted earlier in August 2013. This is due to the nature of the database where providers can update their data throughout the year.]

Local Authority	DoL type				Total
	S39A	S39C	S39D	Not specified	
Barking & Dagenham	1		0		1
Barnet	7	3	5		15
Barnsley	1		0		1
Bath & North East Somerset	5		7		12
Bedford Borough	1	2	10		13
Bexley	0		1		1
Birmingham	17	13	8		38
Blackburn With Darwen	11		5		16
Blackpool	6		4		10
Bolton	3		6		9
Bournemouth	15	1	33		49
Bracknell Forest	1		0		1
Bradford	20	2	8		30
Brent	2	1	1		4
Brighton & Hove	2		0		2
Bristol	12	1	28	34	75
Bromley	1		2		3
Buckinghamshire	2		0		2
Bury	1		3		4
Cambridgeshire	4		17		21
Camden	10	16	2		28
Central Bedfordshire	0		1		1
Cheshire	15	2	3		20
Cornwall	10	1	18		29
Coventry	3		6		9
Croydon	3	2	3		8
Cumbria	1	5	1		7
Derby	8		1		9
Derbyshire	41	3	25		69
Devon	5		12		17
Doncaster	5	2	3		10
Dorset	5	2	33		40
Dudley	2		13	1	16
Durham	0	2	0		2
Ealing	0		0		0
East Riding Of Yorkshire	0	1	0		1
East Sussex	6	1	3		10
Enfield	6		0		6
Essex	24	5	39		68

Tables by local authorities

Local Authority	DoL type				Total
	S39A	S39C	S39D	Not specified	
Gateshead	0		5		5
Gloucestershire	16		12		28
Greenwich	0		1		1
Hackney	7	7	2		16
Halton	0		1		1
Hammersmith & Fulham	2		1		3
Hampshire	8		21		29
Haringey	6		0		6
Harrow	1		0		1
Hartlepool	1		0		1
Havering	3		0		3
Herefordshire	4	4	7		15
Hertfordshire	9		27		36
Hillingdon	1		0		1
Hounslow	2		3		5
Isle Of Wight	0		4		4
Islington	5	4	3		12
Kensington & Chelsea	1		1		2
Kent	17		3	1	21
Kingston Upon Hull	0		0		0
Kingston Upon Thames	1		0		1
Kirklees	8		1		9
Knowsley	0		0		0
Lambeth	10		3		13
Lancashire	19		52		71
Leeds	21	1	13	1	36
Leicester	18	1	3		22
Leicestershire	26	3	1	1	31
Lewisham	1		0		1
Lincolnshire	13		25		38
Liverpool	5	1	10		16
Luton	0		4		4
Manchester	27	21	9		57
Medway Towns	1		0		1
Merton	0	1	0		1
Middlesbrough	8		0		8
Milton Keynes	0		0		0
Newcastle Upon Tyne	5	1	1		7
Newham	3	1	5		9
Norfolk	3	2	2		7
North East Lincolnshire	1		0		1
North Lincolnshire	5	1	0		6
North Somerset	2	1	24	2	29
North Tyneside	0		0		0
North Yorkshire	6	1	1		8
Northamptonshire	8		2		10

Local Authority	DoL type				Total
	S39A	S39C	S39D	Not specified	
Northumberland	0		0		0
Nottingham	14		0		14
Nottinghamshire	14	1	7		22
Oldham	6	1	1		8
Oxfordshire	5		40		45
Peterborough	1		4		5
Plymouth	8		2		10
Poole	5		7		12
Portsmouth	4		7		11
Reading	3		1		4
Redbridge	0		0		0
Redcar & Cleveland	1		0	1	2
Richmond Upon Thames	1		0		1
Rochdale	1		0		1
Rotherham	5	1	2		8
Rutland	3		0		3
Salford	1		0		1
Sandwell	1		3		4
Sefton	2		0	1	3
Sheffield	26	1	15		42
Shropshire	3	2	2		7
Slough	3	2	0		5
Solihull	0		0		0
Somerset	9		21		30
South Gloucestershire	5	1	17		23
South Tyneside	0		6		6
Southampton	6		4		10
Southend	2		1		3
Southwark	8		5		13
St Helens	4		0		4
Staffordshire	11		10		21
Stockport	0		1		1
Stockton On Tees	3		0		3
Stoke-On-Trent	7		2		9
Suffolk	5		13		18
Sunderland	6		1		7
Surrey	9		0		9
Sutton	0		0		0
Swindon	4		7		11
Tameside	0		2		2
Telford & Wrekin	4	1	0		5
Thurrock	6		1		7
Torbay	8		2		10
Tower Hamlets	4	2	1		7
Trafford	0		0		0
Wakefield	7		3		10

Tables by local authorities

Local Authority	DoL type				Total
	S39A	S39C	S39D	Not specified	
Walsall	1		0		1
Waltham Forest	2		6		8
Wandsworth	2	1	2		5
Warrington	8	1	1		10
Warwickshire	1		6		7
West Berkshire	1		0		1
West Sussex	17	2	6		25
Westminster	6		1		7
Wigan	50	2	10	1	63
Wiltshire	2		4	2	8
Windsor & Maidenhead	6		2		8
Wirral	10	2	0		12
Wokingham	1		1		2
Wolverhampton	5	1	10		16
Worcestershire	25	5	8		38
York	4		3		7
Total	**886**	**141**	**796**	**45**	**1,868**

Appendix: Useful guides and research

- For case law and discussion on the MCA:

  http://www.mentalhealthlaw.co.uk

  http://www.39essex.com/resources/newsletters.php

- For DOLS information:

  http://www.dh.gov.uk/health/2012/09/dolsfactsheet/

  Good practice guidance, October 2013:

  http://www.scie.org.uk/publications/reports/report66.asp

- Action for Advocacy's Quality Performance Mark for advocacy / IMCA services

  Action for Advocacy (A4A), the advocacy sector's umbrella organisation, has ceased operations. One of A4A's functions was the delivery of the Quality Performance Mark (QPM), a tool for providers of advocacy to demonstrate their ability to provide high quality advocacy.

  At the request of the A4A Board, NDTi is undertaking a consultation-exercise to re-design and re-launch the advocacy QPM. The NDTi have commenced a series of events to involve registered organisations and those seeking accreditation in the development of the revised QPM. http://www.ndti.org.uk/major-projects/advocacy-quality-performance-mark/

- Good practice guides published by ADASS and SCIE on:

  Deprivation of Liberty safeguards

  http://www.scie.org.uk/publications/ataglance/ataglance43.asp

  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

Independent Mental Capacity Advocate

Report Writing Evaluation Tool

Commissioners and IMCA Managers want to check the quality of the IMCA services they commission. IMCA providers have a responsibility to ensure that the work undertaken by IMCAs is of high quality and is effective advocacy.

Sampling IMCA reports (anonymised so that confidentiality is not compromised) can be a useful way of checking the quality of representation offered by IMCA services. Commissioners may also consider including the requirements for high quality IMCA reports in IMCA contracts.

The attached checklist can also be a useful tool for IMCA managers and IMCAs when evaluating the quality of IMCA reports in IMCA services .It was drawn up by Empowerment Matters and is reproduced here with their permission.

Independent Mental Capacity Advocate
Report Writing Evaluation Tool

General	✓
Is the report well written and does it conform to the IMCA provider's report template?	
Is the report person centred? Does it identify the client's wishes, feelings, beliefs and values? If this has not been possible, is the reason is stated?	
Are statements in the report clearly evidenced?	
Has the report been sent to the decision maker without unnecessary delay?	
Is the report evidence-based and balanced – has the IMCA looked at the pros and cons of each possible decision and included opinions from all those involved?	
Is there a conclusion that provides an analysis of best interests using the evidence gathered (balance sheet approach)?	
Reports should include	
Information from and about the person	
Details of what the client has expressed about the decision or any other information about what is important to them and how this has been established.	
Detailed information about the person's history that may give insight into the uniqueness of that person.	
A summary of the person's current situation, the decision to be made and how the decision will affect them.	
Information about the person gathered from records and people involved in the person's life.	
Actions the IMCA took	
People the IMCA consulted. Any quotes are attributed.	
Relevant information from the IMCA's research including information from CQC reports.	
Relevant details from the person's health and social care records that the IMCA has accessed.	
Details of any visits made to services e.g. prospective care homes.	
Anything else the IMCA is asking the decision maker to consider	
Alternative courses of action suggested by the IMCA.	
Issues not directly related to the decision that should be highlighted eg if the person needs ongoing advocacy.	
Any relevant case law.	
Particular aspects of the MCA that the IMCA wants to highlight eg if the person could be better supported to take part in the decision-making process.	

In addition to the relevant information above, some specific information should be included in IMCA reports depending on the type of decision.	✓
Serious Medical Treatment decisions	
The treatment option(s) under consideration.	
Potential risks, benefits and burdens of each proposed treatment and/or the option not to treat.	
The likely impact of the proposed treatment/not to treat on the person.	
Whether a second medical opinion is being requested by the IMCA.	
Matters in relation to End of Life care should be included.	
Details of IMCA involvement in any DNACPR considerations.	
Any personalised care or reasonable changes under DDA.	
Change of Accommodation decisions	
Current living situation and rationale for proposed move.	
Accommodation options being considered by the LA/NHS.	
If alternative accommodation is being considered on person's discharge from hospital, the original reasons for hospital stay.	
Specific factors to be considered for the person about the potential impact of the move (e.g. where accommodation is, staff & support, family, presence in the community, maintaining relationships).	
Support the client may need during/after any move.	
Care Reviews	
Purpose of the review is stated (eg annual review, person's needs have changed, registration issues, home closure, recent best interests decision made about person's accommodation).	
Concerns about the care plan/provision of care/support provided/potential home closure are highlighted.	
Any issues outstanding from a previous change of accommodation decision that have not been addressed.	
Any issues regarding the person's continued placement at the accommodation are highlighted.	
Concerns about a potential unidentified DoL, where relevant.	
Safeguarding	
Details of the alleged abuse.	
Protective measures being considered or applied.	
The person's views and wishes in relation to the protective measures and how these have been determined.	
Other factors to consider in making decisions about the protective measures.	
Any comments or concerns regarding the safeguarding adults process.	
Deprivation of Liberty Safeguards	
Is there a deprivation of liberty and if so is it in the person's best interests?	
Any suggested conditions or comments regarding the best interests assessors recommendations.	
A recommendation of the duration of the DoL.	
Any suggestions about who could be the relevant person's representative.	
Any comments regarding the person's capacity/mental health assessment.	

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