

**THE SECOND YEAR OF
THE INDEPENDENT
MENTAL CAPACITY
ADVOCACY SERVICE**

2008/2009

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CONTENTS

- 1. SUMMARY 1

- 2. MAIN REPORT 2
 - I. INTRODUCTION: THE ORIGIN OF THE IMCA SERVICE 2
 - II. THE IMCA ROLE 3
 - WHO BENEFITS 4
 - ACCOMMODATION MOVES AND REVIEWS 5
 - SERIOUS MEDICAL TREATMENT 6
 - ADULT PROTECTION 8
 - PROCESSES AND OUTCOMES 10

- APPENDIX 1. TABLES TO MAIN REPORT 11

- APPENDIX 2: RESEARCH ON VIEWS ON THE SECOND YEAR, BY CARYS BANKS AND MARCUS REDLEY, CAMBRIDGE UNIVERSITY 44

THE INDEPENDENT MENTAL CAPACITY ADVOCACY SERVICE: THE SECOND YEAR (2008-9)

1. SUMMARY

1. The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service as a safeguard for people without the capacity to make certain important decisions. The Act also introduced **a legal duty** on NHS bodies and local authorities to refer eligible people to the IMCA service. The IMCA service started on 1st April 2007 and this is the report on its **second year's work**.
2. The role of the IMCA has been to represent and support people without capacity, and mainly without family or friends to support them, in important decisions. Six thousand, five hundred and eighty two (6582) people received representation from the IMCA service in its second year. **This is a 27% increase from last year.**
3. Three thousand and four hundred and ninety six (3496) of the representations were for decisions on accommodation moves. This is an increase of 14% over the last year. Three hundred and eighty seven people (387) were represented in care reviews; this is an increase of 102% from a low base. Nine hundred and sixty eight (968) people were represented in decisions about serious medical treatment, which is a 43% increase and 960 were represented in adult protection proceedings, which is a 29% increase.
4. The Department of Health is pleased that there has been an increase in referrals, to reflect the greater awareness of the IMCA service. At the same time, a greater rate of increase had been expected, and it is not thought that the IMCA service is reaching all the people it needs to as yet. Concern remains about the continuing low referral levels for serious medical decisions in the NHS. Concern also remains about the low level of adult protection referrals. It is not clear that local authorities understand they must consider for each adult protection referral received whether the individual would benefit from an IMCA.
5. There are also large variations amongst different geographical areas, both in relation to total number of referrals and numbers of referrals for serious medical treatment and adult protection. In some areas numbers of referrals have gone down, which is surprising (Tables B and C).
6. In a small study of stakeholder experiences, carried out by Carys Banks and Marcus Redley, commissioners reported they were mainly pleased with their IMCA services, although they did want IMCAs to be more available and IMCA reports to be delivered faster. IMCA Managers reported an improved image and confidence of statutory advocacy, but raised concerns about future funding levels in the context of rising referrals. MCA leads in hospitals thought that those healthcare practitioners using the IMCA service benefited from it; although they also thought many more did not use it. They said that there was a perception within health care settings that involving an IMCA delayed treatment. MCA leads in local authorities were more positive and commented on the professionalism of IMCAs and the benefits to the client group.

2. MAIN REPORT

Six thousand, five hundred and eight two (6582) people who lacked capacity were represented by the IMCA service in 2008-9, in England, in its second year of operation.

This is an increase of 27%.

I. INTRODUCTION: THE ORIGIN OF THE IMCA SERVICE

1. The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service. We start this report, of the second year's work, again with the same comment from the then Lord Chancellor:

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

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

2. The Act created the Independent Mental Capacity Advocate (IMCA) service – and equally importantly - **the legal duty** to instruct the IMCA service in certain situations. The purpose of the IMCA Service is to help particularly vulnerable people who lack the capacity to make specific important decisions; it was created as a safeguard for decision making for particularly vulnerable people.
3. The duty to instruct the IMCA service applies to specific decisions in relation to people who lack capacity to make those decisions. The decisions identified in the Act are: 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 situations and care reviews. Apart from adult protection cases where this criteria does not apply, eligibility is targeted to those without the support of family and friends to assist in the decision making.
4. The duty in the Act is highly targeted. It is targeted at the most vulnerable people – those who have no one to support and represent them – and the decisions which are the most common and have the most far reaching consequences for the individuals: serious medical treatment and long term moves. However IMCAs can, and are being used in a wider role in some local authorities. There is nothing in the ACT which restricts the work of the IMCAs to their statutory duties. They can – for example – be commissioned by local authorities to act as advocates in direct payments for/with people who lack capacity.

5. The Act is based on five statutory principles, which are the values that underpin the legal requirements in the Act and underpin also the work of the IMCA service. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to.
6. The five statutory principles are:
 1. A person must be assumed to have capacity unless it is established that they lack capacity.
 2. A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
 3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
 4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests.
 5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

II. THE IMCA ROLE

7. The IMCA's role is to support and represent a person in decisions being made by others on their behalf. The IMCA meets with the person and tries to establish the person's past and present wishes; their feelings, beliefs and values. This sometimes involves verbal communication and discussion. Where this is not possible, for example if a person has no speech, it involves communication using other means, such as pictures or signs. Sometimes no direct communication is possible. Then the role is to find out as much as possible about the person from the files and from other people who have known them.
8. The other part of the role is to examine the decision making process. For example the IMCA's role involves ascertaining if the decision maker has given 'all practical and appropriate support' to help the person be involved in decision making. If the person has communication difficulties, it is the IMCA's role to find out if any specialist help has been accessed, such as the help of a speech and language therapist.
9. IMCAs work to gather as much as information as possible. The IMCA has a right to access relevant information in healthcare and in social care files. The IMCA interviews people they consider relevant. IMCAs then write a report bringing all this information together and thereby feeding into the decision making process. Sometimes this is the first time that a person's life history is documented and the first time that the person and his or her experiences and values are brought together into a report. The decision maker has to consider the report.

WHO BENEFITS?

Six thousand, five hundred and eight two (6582) people who lacked capacity were represented by the IMCA service in 2008-9, in England, in its second year of operation.

This is an increase of 27%.

The clients:

**54% were women
34% were aged 80 or over
36% had dementia
22% had learning disabilities
13% had mental health needs
4% had acquired brain injuries
2% had autism**

+ some people had a combination of conditions

10. In the second year, six thousand five hundred and eighty two people who lacked capacity were supported and represented by the IMCA service (Table 1). This is an increase of 27% nationally.
11. Fifty four per cent of the clients were women, reflecting perhaps the age distribution and that more women live longer. Fifty eight per cent were over the age of 66 – and of these 34 per cent were aged 80 and over, demonstrating that some very elderly and frail people are benefiting from the IMCA service. The largest increase in the last year was for people aged 80+ , and over 500 more people received an IMCA service in the second year. **In 2008-9 a total of 2258 people aged 80 and over had the help of an IMCA.** (Table 4)
12. Eighty-eight per cent of the clients were of white ethnic background; of the others the largest groups was of Caribbean origin. People had a wide variety of impairments, but dementia was the largest group, making up 36% of cases, followed by people with learning disabilities (22%), people with mental health needs (13%) and people with acquired brain injuries (4%) – (Table 6)
13. The 6582 cases are divided into the four types of cases: accommodation moves, reviews, serious medical treatment and adult protection and are examined separately.

ACCOMMODATION MOVES AND REVIEWS

14. The Act imposes a duty on NHS bodies and local authorities who are responsible for long term **accommodation decisions** to involve an IMCA. This applies to people who lack the capacity to make the decision, who have no friends or family to support them in the decision making; and whose accommodation in hospital is expected to be for 28 days or more or 8 weeks or more in a care or nursing home or other form of arranged accommodation.
15. The most frequent type of referral received by IMCAs in the second year, as in the first year, was for accommodation moves. IMCAs represented three thousand and four hundred and ninety six (3496) people in relation to decisions being made about their long term care moves. This means of all the people that IMCAs support, some 47%, or nearly half, are supported in decisions around accommodation moves. The largest proportion of these accommodation decisions were for people in hospital, at the time of the decision – this accounted for 40% of all accommodation moves or (1370 people). This was followed by 964 people moving from care homes, mainly to other care homes or nursing homes – which was 28% of the accommodation moves and 764 people moving from their own homes, mainly into care homes - which was 22% of all accommodation moves. (Table 9)
16. The statistics offer some insight into the results of the decisions being made. Of those people who were living in their own homes, only 4 people, less than one percent were able to carry on living at home. For the vast majority, the decision was that they needed to move. Of those in hospital at the time of the IMCA referral, 58 were able to go home, which is about 5%. Out of the 690 who were in a care home at the point of referral, 34 people (4%) were able to go home. There were also some people who moved to supported living. This shows that at the point at which IMCAs receive referrals, most decisions are being made to move people into institutional care. IMCAs' contribution in these cases is a) to provide the safeguard to make sure the decisions made are actually in people's best interests and b) to feed information about people's beliefs and values and life styles into the specific accommodation being arranged.
17. Reviews were introduced in the MCA regulations as decisions where IMCAs could be invited to be involved, without there being a duty to instruct them. The rationale for this extension of the MCA was to create a second opportunity for reviewing whether an accommodation move had been in the best interests of a person who had not been able to consent to it or whether an alternative might at this point be more in their best interests. The expectation was that local authorities would develop policies identifying which individuals would most benefit and where the use of this power was most useful and offer clear guidance to their staff. At the end of the second year, few such policies appear to exist and it appears a little haphazard when IMCAs are invited back to

reviews and when they are not. IMCAs reported that they thought reviews were not routinely carried out in many places.

18. Three hundred and eighty seven (387) referrals had been made for care reviews in the second year. This is a low number compared to the number of accommodation referrals, although it is a large increase from the first year, where there were only 191. (Table 10)

SERIOUS MEDICAL TREATMENT

Definitions

19. There is a duty on NHS bodies to instruct an IMCA whenever they are proposing to take a decision about '**serious medical treatment**', or proposing that another organisation (such as a private hospital) carry out the treatment on their behalf. This duty applies if a) the person does not have the capacity to make the decision themselves and b) there is no one else available to consult (such as friends or family).
20. The Regulations defined serious medical treatment as treatment which involves giving new treatment, stopping treatment or withholding treatment, where there is a fine balance between the likely benefits and the risks; or where a decision between a choice of treatments is finely balanced; or what is proposed is likely to have serious consequences.
21. The duty is to instruct an IMCA – i.e. first to refer a patient to an IMCA and then to take into consideration the IMCA's report about the person's wishes and preferences. The decision whether or not to carry out the serious medical treatment remains the decision of the doctor, consultant or medical team.

Referrals

22. The second year of the statutory IMCA service had 968 referrals for people who were being considered for serious medical treatment, which is an increase of 43%.

Referrals for Serious Medical Treatment

Nine hundred and sixty eight people benefited from the IMCA service in relation to serious medical treatment during the second year. This is an average of six cases per PCT in a year – or one every two months.

23. The level of referrals during serious medical treatment decision making has risen, which is a positive sign. There were concerns in year one that:
 - a) Some doctors do not understand that there is a statutory duty to make referrals. They perceive it as discretionary.
 - b) Some doctors do not agree with the statutory duty to make referrals. They choose to disregard it.

24. There is clearly some improvement. Nearly a thousand medical staff referred patients to IMCAs, in the context of decision making on conditions as varied as cancer treatment, major amputations, other forms of major surgery and DNAR decisions. (Table 11)
24. In Nottingham, where IMCA services moved onto a hospital ward for four weeks, the IMCA service did not find many additional patients who qualified for an IMCA, but did find there was a large continuing role for educating staff about the Mental Capacity Act. The IMCA service also found that there was worry in acute settings about IMCAs delaying discharge, and admissions procedures needed to be reviewed to incorporate the flagging up of people who may need an IMCA on admission.
25. One hundred and five dentists made referrals to IMCAs while making serious dental decisions. IMCAs reported that they had been involved in representing clients with learning disabilities, whose teeth had been badly neglected for many years, because some residential care staff in some instances and family members in other cases had not taken them to dentists.
26. Where referrals have been made, the feedback continues that IMCAs do have a part to play in the decision making process about serious medical treatment. For some decisions it is a modest part, mainly asking questions about the proposed treatment. It may focus mainly on a checking process that 'the person' has been considered as much as the disease. For others it is a larger part, where the information about the person – his past wishes, his preferences, his desired quality of life – helps the decision making medical professional make the decision when the decision is, as the definition states, finely balanced.
27. And finally there are some few consultants who have become champions of the IMCA service. The consultant who told his colleagues that he likes his decisions being questioned because it makes him think harder about each and every one of his decisions is rare but not unique. As the wider agenda of patient choice, patient empowerment and consulting with family and relatives becomes more accepted, the use of an IMCA is expected to rise. Doctors value the fact that someone has identified in a report the wishes and feelings of patients who cannot voice their views and this plays a part in the decision making, in the same way that the views of a relative or friend might.
28. The Department of Health's conclusion about referrals to IMCAs in the context of serious medical decision making, is that referrals have increased and need to continue to increase.

ADULT PROTECTION

29. IMCA referrals for adult protection have risen from 681 last year to 960 this year. This is an increase of 29%. Regulations enable local authorities and NHS bodies to instruct an IMCA to support and represent a person who lacks capacity where a) it is alleged that the person is or has been abused or neglected by another person; or b) where it is alleged that the person is abusing or has abused another person. This means that if they lack capacity, both victims and perpetrators can benefit from the support of the IMCA service. Furthermore there is no requirement for the person to have no family or friends in this situation. The duty of the local authority is to consider – for each person – whether they might benefit from an IMCA. The Department of Health is concerned that this duty to consider the specific benefit of an IMCA is not being properly applied to every individual. In only 20 local authorities were IMCA referrals made to more than 10 safeguarding cases. Is it really the judgement of local authority safeguarding staff that all the other vulnerable adults referred into safeguarding would not benefit from an IMCA?
30. Nearly a thousand people benefited from having an IMCA in adult protection cases in the last year (Table 12). IMCAs continue to report that adult protection cases were some of the most complicated cases they were involved with. IMCAs struggled to balance supporting the person with the collection of views/ evidence and working with families was challenging. As a result a piece of research was commissioned to examine these issues and this was reported in the summer of 2008¹.
31. A number of Adult Protection Co-ordinators were asked their views of the involvement of IMCAs in adult protection cases. Many were very positive. Comments included that IMCAs were very good at focusing entirely on the client during strategy meetings, thereby freeing up the Co-ordinators to co-ordinate professionals. IMCAs were said to be good at championing the voice of the client. Some commented they were excellent at finding long lost relatives and collecting contextual information about lives of clients prior to the incident being investigated. A small number of Safeguarding Co-ordinators said they did not need IMCAs in adult protection, they could do it all themselves.

¹ <http://www.scie.org.uk/publications/imca/information/imcas.asp>

IMCA Case Study

Referral:

AN IMCA organisation receives a referral from a community social worker for a 71 year old client who has a diagnosis of end stage renal failure. At the time of the referral the client was bed bound and being supported at home by her partner and four visits from home care per day. It is a referral for a possible accommodation move.

The client had been with her partner for approximately ten years, they were known to have had a volatile relationship. He is supported by the CMHT and is known to have a chaotic lifestyle. During the IMCA's involvement, the home care workers visiting her one morning contacted the police because they believed she may have been raped by her partner. Her physical health has also deteriorated to the extent such that she is unable to communicate. She is placed in a Nursing Home as a safeguarding measure whilst the police investigation is undertaken.

The referral now concerns two decisions that need to be made: a possible accommodation move on grounds of her health and a safeguarding plan. The team manager is named as decision maker. Both he and the GP undertake capacity assessments and conclude that she lacks capacity in relation to both of these decisions due to her inability to communicate.

The IMCA initially visits with the police officer. The client is non responsive to all attempts at communication. The IMCA visits unaccompanied two weeks later. Her health has improved to the extent that she is able to engage in conversation. She describes being unhappy at the nursing home and states that she wishes to return home. When she is asked if she would feel safe at home she replies that she would not but refuses to elaborate on this. She states that she does not wish to consider moving to an alternative home and cannot think of any way the staff can improve her experience of where she is. She asks to see her partner and states that she misses him.

Staff at the home report that her physical health has improved and stabilised but anticipate that she will deteriorate again in the near future. They feel that she requires twenty four hour support and that her needs could not be easily met with a home care package.

PROCESSES AND OUTCOMES

32. The statistical database records two questions about **the relationship between the referrers and the IMCA service**. The first question is how well the local authority or NHS is thought to have worked with the IMCAs. Two thirds of the IMCAs reported the local authority or NHS worked 'very well' with them plus another 28% said they worked well. In only 21 cases – less than one percent - were the local authority or NHS considered to have worked 'not well' with the IMCA service.(Table 13)
33. The second question is a question requiring self reflection: it asked how well did the IMCA service work with the local authority/NHS. The results were similar: Some 88% thought they had worked very well or well. Only in 40 cases – in less than 2% of the cases did IMCAs think they had not worked well with the local authority or NHS. (Table 14)
34. These are obviously subjective questions, but they do seem to record that working together is perceived by IMCAs to be good or very good in both directions. Where referrals are made, both decision makers and advocates understand each other's roles and work together without major problems.
35. A question was asked about how often IMCAs were able to ascertain the wishes of their clients who lacked capacity to make the decision in question. IMCAs reported that they were able to do so in 66% of cases. (Table 15) This is commendable. It meant working very carefully with people with dementia to ensure they could maximise their, often fluctuating, capacity to understand and communicate and equally carefully with people with learning disabilities and brain injury and other conditions with varying degrees of verbal communication. In the other one third cases, IMCAs needed to rely on information from records, from interviewing other people and from researching the situation.
36. Seventy percent of IMCAs thought that the final decision made did represent the wishes of the client, and an additional 22.5 per cent thought they partly did. This – 92% - is a very high figure. In 55% of cases IMCAs thought the outcome had been significantly affected by their involvement and in 12% of cases the IMCA had challenged the decision that was made. (Table 16)
37. IMCAS recorded that they submitted reports in 63% of the cases. It is not clear why this figure is so low.(Table 21)
38. This report relies heavily on the IMCA database and the views of IMCAs. The figures reflect the data inputted by IMCAs. In addition to this, the Department of Health commissioned Cambridge University to carry out a small piece of research, recording the views of other people and this is included in this annual report.

APPENDIX 1. TABLES TO MAIN REPORT

Table A) Total eligible referrals to IMCAs in year 2

Local Authority	Organisation	No. referrals
Surrey	Just Advocacy/ Kingston Advocacy	179
Cornwall	SEAP	175
Manchester	Rethink	164
Leeds	Leeds Advocacy	160
Kent	SEAP	138
Birmingham	Advocacy Matters- Boldmere	130
Suffolk	Optua	128
Hampshire	Hampshire Advocacy	125
Devon	Age Concern	121
Norfolk	Rethink	121
Essex	Age Concern/Together for Wellbeing	117
Hertfordshire	PoHwer	111
Gloucestershire	Advocacy Trust Gloucestershire	108
Lancashire	E Lancashire Advocacy/ Central Advocacy/N-Compass	108
Bristol	Bristol MIND	100
Lincolnshire	Speaking Up	98
Liverpool	Advocacy Experience	98
Sheffield	Speaking Up	93
West Sussex	Advocacy Partners	90
Derbyshire	Derbyshire MIND/Derbyshire Advocacy	84
North Yorkshire	Cloverleaf Advocacy	83
Kirklees	Together for Wellbeing	82
Staffordshire	ASIST	80
Camden	Advocacy Partners	77
Cumbria	Advocacy Experience	76
Somerset	Advocacy in Somerset	76
Dorset	Dorset Advocacy	73
Barking and Dagenham	HUBB	71
Lambeth	Cambridge House	69
Bradford	Choice Advocacy/Bradford + Airedale MH Advocacy Group	66
Cambridgeshire	Speaking Up	64
Plymouth	Plymouth Highbury Trust	64
Cheshire	IMCA Consortium	60
East Sussex	Advocacy Partners	60
Havering	HUBB	60
Wakefield	Together for Wellbeing	59
Leicester	PoHwer	56
Warwickshire	PoHwer	56

Local Authority	Organisation	No. referrals
Nottinghamshire	Speaking Up	55
Enfield	Rethink	54
Torbay	Living Options	53
Waltham Forest	PoHwer	52
Stockport	Advocacy Experience	50
Stoke On Trent	ASIST	50
Bournemouth	Dorset Advocacy	48
Bath and North East Somerset	Bath MIND	47
Tameside	Advocacy Experience	47
Worcestershire	PoHwer	47
Derby	Derbyshire Mind/Derbyshire Advocacy	46
Croydon	Advocacy Partners	45
Oxfordshire	Oxfordshire Advocacy Development Group	45
Wandsworth	Advocacy Partners	44
Durham	Skills for People	43
Sefton	Advocacy Experience	43
Sunderland	Age Concern Sunderland	43
Barnet	Rethink	42
North Somerset	Advocacy Services @ The care Forum	42
Kensington and Chelsea	Cambridge House	41
Swindon	Swindon Mind	41
Wigan	Wigan Family Welfare	41
Nottingham	Speaking Up	40
Northamptonshire	Speaking Up	39
Southampton	Choices Advocacy	39
Salford	North West Advocacy Service	37
York	Cloverleaf Advocacy	36
Islington	Advocacy Partners	35
Kingston Upon Thames	Kingston Advocacy Group	35
Wiltshire	SWAN	35
Lewisham	Cambridge House	34
Newham	MENCAP	34
Westminster	Cambridge House	34
Leicestershire	PoHwer	33
Wirral	Wired	33
Bromley	Cambridge House	32
Haringey	Rethink	32
Portsmouth	SEAP	32
South Tyneside	Your Voice Counts	32
Tower Hamlets	Advocacy Partners	32

Local Authority	Organisation	No. referrals
Southwark	Cambridge House	31
Coventry	PoHwer	30
Rochdale	Rochdale and District Mind	30
Warrington	North West Advocacy Service	30
Hammersmith and Fulham	Cambridge House	29
Poole	Dorset Advocacy	29
Bedfordshire	PoHwer	27
Brighton and Hove	Advocacy Partners	27
Buckinghamshire	Aylesbury Vale Advocates/ Age Concern Bucks	27
Calderdale	Cloverleaf Advocacy	27
Ealing	Cambridge House	27
Oldham	Advocacy Experience	27
East Riding	Cloverleaf Advocacy	25
Newcastle Upon Tyne	Skills for People	25
South Gloucestershire	Advocacy services@ The Care Forum	25
Barnsley	Speaking Up	24
Isle of Wight	Solent MIND	24
Shropshire	PoHwer	24
Blackburn with Darwen	East Lanc Advocacy/ Central Advocacy/N-Compass	23
Brent	Cambridge House	23
Hertfordshire	PoHwer	23
Milton Keynes	People's Voices	23
North Tyneside	Skills for people	23
Bury	Advocacy Experience	22
Richmond U Thames	Kingston Advocacy Group	22
Doncaster	Speaking Up	21
Rotherham	Speaking Up	21
Harrow	Cambridge House	20
Reading	Matrix	20
Sutton	Advocacy Partners	20
Greenwich	Cambridge House	19
North Lincolnshire	Cloverleaf Advocacy	19
Trafford	North West Advocacy Service	19
Dudley	Dudley Advocacy	18
Kingston Upon Hull	Cloverleaf Advocacy	18
Medway Towns	SEAP	18
Middlesborough	Skills for People	18
Telford and Wrekin	PoHwer	18

Local Authority	Organisation	No. referrals
Wolverhampton	PoHwer	18
Hartlepool	Skills for People	17
Hillingdon	Cambridge House	17
Knowsley	North West Advocacy Service	17
Redbridge	Speaking Up	17
Blackpool	East Lancs Advocacy/ Central Advocacy/ N-Compass	16
Hackney	PoHwer	16
Merton	Advocacy Partners	16
Sandwell	PoHwer	16
Hounslow	Cambridge House	15
Luton	PoHwer	15
Solihull	PoHwer	15
Bolton	North West Advocacy Service	14
Southend	Together for Well Being	14
Darlington	Skills for People	13
Halton	North West Advocacy Service	13
NE Lincolnshire	Speaking Up	12
Northumberland	Spiral Skills	12
Bexley	Cambridge House	11
Peterborough	Speaking Up	11
St Helens	North West Advocacy Service	10
West Berkshire	Matrix	10
Bracknell Forest	Matrix	8
Gateshead	Skills for People	7
Slough	Matrix	7
Stockton on Tees	Skills for People	7
Wokingham	Matrix	6
Walsall	PoHwer	5
City of London	Mencap	0
Isles of Scilly	SEAP	0
Redcar + Cleveland	Skills for People	-
Rutland	PoHwer	-
Thurrock	Thurrock Mind/Speaking Up	-
Windsor and Maidenhead	Matrix	-
England	Totals	6582

A dash (-) = less than 5 cases

Table B) Adult protection referrals to IMCAs in year 2

Local Authority	Organisation	No. referrals
Cornwall	SEAP	50
Devon	Living options and Age Concern	43
Birmingham	Advocacy Matters - Boldmere	33
Kirklees	Together for Wellbeing	30
Essex	Age Concern / Rethink	28
Leeds	Advocacy Leeds	24
Suffolk	Optua	22
Plymouth	Plymouth Highbury Trust	21
Derbyshire	Derbyshire MIND/Derbyshire Advocacy	20
Somerset	Advocacy in Somerset	20
Hertfordshire	PoHwer	19
Sheffield	Speaking Up	16
Staffordshire	ASIST	14
Torbay	Living options and Age Concern	14
Wakefield	Together for Wellbeing	14
North Yorkshire	Cloverleaf Advocacy	13
East Sussex	Advocacy Partners	12
North Somerset	Advocacy Services @ The Care Forum	12
Warrington	North West Advocacy Service	12
Croydon	Advocacy Partners	11
Wigan	Wigan Family Welfare	11
Bristol	Bristol Mind	10
Dorset	Dorset Advocacy	10
Lincolnshire	Speaking Up	10
Stockport	Advocacy Matters Ltd	10
Bradford	Bradford & Airedale Mental Health Advocacy Group/ Choice advocacy	9
Cheshire	Various for cheshire	9
Stoke On Trent	ASIST	9
Warwickshire	PoHwer	9
Wiltshire	SWAN	9
Bedfordshire	PoHwer	8
Cambridgeshire	Speaking Up	8
Cumbria	Advocacy Matters Ltd	8
Enfield	Rethink	8
Knowsley	North West Advocacy Service	8
Lancashire	East Lancs Advocacy, Preston advocacy, Wyre and Flyde Advocacy	8

Local Authority	Organisation	No. referrals
Leicestershire	PoHwer	8
North Tyneside	Skills for People	8
South Gloucestershire	Advocacy Services @ The Care Forum	8
Tameside	Advocacy Matters Ltd	8
Worcestershire	TBC	8
Leicester	PoHwer	7
Liverpool	Advocacy Matters Ltd	7
Northamptonshire	User Support Service and Advocacy Northants	7
Oldham	Advocacy Matters Ltd	7
Rotherham	Speaking Up	7
Waltham Forest	PoHwer	7
Bath and North East Somerset	Bath Mind	6
Durham	Skills for People	6
Hampshire	Hampshire Advocacy Regional Group	6
Kingston Upon Hull	Cloverleaf Advocacy	6
Newham	Age Concern Newham, Mencap...	6
Norfolk	Rethink	6
Oxfordshire	Oxfordshire Advocacy	6
Salford	North West Advocacy Service	6
Sefton	Advocacy Matters Ltd	6
Tower Hamlets	Advocacy Partners	6
West Sussex	Advocacy Partners	6
Wolverhampton	PoHwer	6
Barking and Dagenham	HUBB	-
Barnet	Rethink	-
Barnsley	Speaking Up	-
Blackburn with Darwen	East Lancs Advocacy & Preston Advocacy	-
Blackpool	East Lancashire Advocacy/ Wyre and Flyde Advocacy	-
Bolton	North West Advocacy Service	-
Bournemouth	Dorset Advocacy	-
Bracknell Forest	MATRIX ADVOCACY SERVICE	-
Brent	Cambridge House	-
Brighton and Hove	Advocacy Partners	-
Bromley	Cambridge House	-
Buckinghamshire	Aylesbury Vale Advocacy	-

Local Authority	Organisation	No. referrals
Bury	Advocacy Experience	-
Calderdale	Cloverleaf Advocacy	-
Camden	Advocacy Partners	-
Coventry	PoHwer	-
Darlington	Skills for People	-
Derby	Derbyshire MIND/Derbyshire Advocacy	-
Doncaster	Speaking Up	-
Dudley	Dudley Advocacy	-
Ealing	Cambrige House	-
East Riding	Cloverleaf Advocacy	-
Gateshead	Skills for People	-
Gloucestershire	Citizen Advocacy Trust	-
Greenwich	Cambridge House	-
Hackney	PoHwer	-
Halton	North West Advocacy Service	-
Hammersmith and Fulham	Cambridge House	-
Haringey	Rethink	-
Harrow	Cambridge House	-
Hartlepool	Skills for People	-
Havering	HUBB	-
Hertfordshire	PoHwer	-
Hillingdon	Cambridge House	-
Hounslow	Cambridge House	-
Isle of Wight	Solent MIND	-
Islington	Advocacy Partners	-
Kensington and Chelsea	Cambridge House	-
Kent	SEAP	-
Kingston Upon Thames	Kinston Advocacy Group	-
Lambeth	Cambridge House	-
Luton	PoHwer	-
Manchester	Rethink	-
Medway Towns	Invicta Advocacy (consortium)	-
Merton	Advocacy Partners	-
Middlesborough	Skills for People	-
Milton Keynes	Peoples Voices	-
Newcastle Upon Tyne	Skills for People	-
North Lincolnshire	Cloverleaf Advocacy	-
Northumberland	Spiral Skills at Learning First	-

Local Authority	Organisation	No. referrals
Nottingham	Speaking Up	-
Nottinghamshire	Speaking Up	-
Peterborough	Speaking Up	-
Poole	Dorset Advocacy	-
Portsmouth	SEAP -	-
Reading	MATRIX ADVOCACY SERVICE	-
Richmond Upon Thames	KAG Advocacy	-
Rochdale	Rochdale and District Mind	-
Rutland	PoHwer	-
Sandwell	PoHwer	-
Shropshire	PoHwer	-
Slough	MATRIX ADVOCACY SERVICE	-
Solihull	PoHwer	-
South Tyneside	Advocacy in Gateshead and South Tyneside	-
Southampton	Choices Advocacy	-
Southend	Rethink	-
Southwark	Cambridge House	-
St Helens	NO NAME YET	-
Sunderland	Age Concern Sunderland	-
Surrey	Just Advocacy / Kingston advocacy group	-
Sutton	Advocacy Partners	-
Swindon	Swindon Mind	-
Telford and Wrekin	PoHwer	-
Thurrock	Speaking Up/ Thurrock mind	-
Trafford	North West Advocacy Service	-
Walsall	PoHwer	-
Wandsworth	Advocacy Partners	-
West Berkshire	MATRIX ADVOCACY SERVICE	-
Westminster	Cambridge House	-
Wirral	Advocacy in Wirral	-
York	Cloverleaf Advocacy	-
None in the following :		
NE Lincolnshire	Stockton on Tess	Redbridge
Lewisham	Redcar & Cleveland	Bexley
Windsor and Maidenhead	Wokingham	
City of London	Isles of Scilly	
England	Totals	960

A dash (-) = less than 5 cases

Table C) Serious Medical Treatment IMCA referrals by local authority in Year 2

Local Authority	Organisation	No. referrals
Surrey	Just Advocacy / Kingston advocacy group	71
Leeds	Advocacy Leeds	28
Liverpool	Advocacy Matters Ltd	28
Lancashire	East Lancs Advocacy, Preston advocacy, Wyre and Flyde Advocacy	27
Bristol	Bristol Mind	25
Hertfordshire	PoHwer	24
Bradford	Bradford & Airedale Mental Health Advocacy Group/ Choice advocacy	23
Camden	Advocacy Partners	20
Birmingham	Advocacy Matters - Boldmere	19
Lambeth	Cambridge House	18
Hampshire	Hampshire Advocacy Regional Group	17
Manchester	Rethink	17
Stoke On Trent	ASIST	17
Cornwall	SEAP	16
East Sussex	Advocacy Partners	16
Gloucestershire	Citizen Advocacy Trust	16
Staffordshire	ASIST	16
Wakefield	Together for Wellbeing	16
Tameside	Advocacy Matters Ltd	14
Essex	Age Concern / Rethink	13
North Yorkshire	Cloverleaf Advocacy	13
Nottinghamshire	Speaking Up	13
Torbay	Living options and Age Concern	12
Derby	Derbyshire MIND/Derbyshire Advocacy	11
Dorset	Dorset Advocacy	11
Suffolk	Optua	11
Warwickshire	PoHwer	11
Kent	SEAP	10
Worcestershire	TBC	10
Cambridgeshire	Speaking Up	9
Cumbria	Advocacy Matters Ltd	9
Derbyshire	Derbyshire MIND/Derbyshire Advocacy	9

Local Authority	Organisation	No. referrals
Devon	Living options and Age Concern	9
ISLINGTON	Advocacy Partners	9
Portsmouth	SEAP	9
Southampton	Choices Advocacy	9
Brighton and Hove	Advocacy Partners	8
Cheshire	Various for cheshire	8
Enfield	Rethink	8
Kirklees	Together for Wellbeing	8
Leicestershire	PoHwer	8
Norfolk	Rethink	8
Oxfordshire	Oxfordshire Advocacy	8
Plymouth	Plymouth Highbury Trust	8
Westminster	Cambridge House	8
Bath and North East Somerset	Bath Mind	7
Newham	Age Concern Newham, Mencap...	7
North Somerset	Advocacy Services @ The Care Forum	7
Salford	North West Advocacy Service	7
Sefton	Advocacy Matters Ltd	7
Wiltshire	SWAN	7
Coventry	PoHwer	6
Kingston Upon Hull	Cloverleaf Advocacy	6
Kingston Upon Thames	KAG Advocacy	6
Lincolnshire	Speaking Up	6
Sunderland	Age Concern Sunderland	6
Barking and Dagenham	HUBB	-
Barnet	Rethink	-
Barnsley	Speaking Up	-
Bedfordshire	PoHwer	-
Blackburn with Darwen	East Lancs Advocacy & Preston Advocacy	-
Blackpool	East Lancashire Advocacy/ Wyre and Flyde Advocacy	-
Bolton	North West Advocacy Service	-
Bournemouth	Dorset Advocacy	-
Brent	Cambridge House	-
Bromley	Cambridge House	-
Buckinghamshire	Aylesbury Vale Advocacy	-

Local Authority	Organisation	No. referrals
Bury	Advocacy Experience	-
Calderdale	Cloverleaf Advocacy	-
Croydon	Advocacy Partners	-
Doncaster	Speaking Up	-
Dudley	Dudley Advocacy	-
Durham	Skills for People	-
Ealing	Cambridge House	-
East Riding	Cloverleaf Advocacy	-
Greenwich	Cambridge House	-
Hackney	PoHwer	-
Halton	North West Advocacy Service	-
Hammersmith and Fulham	Cambridge House	-
Haringey	Rethink	-
Hartlepool	Skills for People	-
Havering	HUBB	-
Hertfordshire UA	PoHwer	-
Hillingdon	Cambridge House	-
Hounslow	Cambridge House	-
Isle of Wight	Solent MIND	-
Kensington & Chelsea	Cambridge House	-
Knowsley	North West Advocacy Service	-
Leicester	PoHwer	-
Lewisham	Cambridge House	-
Luton	PoHwer	-
Medway Towns	Invicta Advocacy Network (consortium)	-
Merton	Advocacy Partners	-
Middlesborough	Skills for People	-
Milton Keynes	Peoples Voices	-
Newcastle Upon Tyne	Skills for People	-
North East Lincolnshire	Speaking Up	-
North Lincolnshire	Cloverleaf Advocacy	-
North Tyneside	Skills for People	-
Northamptonshire	User Support Service and Advocacy Northants	-
Nottingham	Speaking Up	-
Oldham	Advocacy Matters Ltd	-

Local Authority	Organisation	No. referrals
Poole	Dorset Advocacy	-
Reading	MATRIX ADVOCACY SERVICE	-
Redbridge	Speaking Up-Redbridge	-
Rotherham	Speaking Up	-
Sheffield	Speaking Up	-
Shropshire	PoHwer	-
Solihull	PoHwer	-
Somerset	Advocacy in Somerset	-
South Gloucestershire	Advocacy Services @ The Care Forum	-
South Tyneside	Advocacy in Gateshead and South Tyneside	-
Southwark	Cambridge House	-
St Helens	NO NAME YET	-
Stockport	Advocacy Matters Ltd	-
Stockton on Tees	Skills for People	-
Sutton	Advocacy Partners	-
Swindon	Swindon Mind	-
Telford and Wrekin	PoHwer	-
Tower Hamlets	Advocacy Partners	-
Trafford	North West Advocacy Service	-
Waltham Forest	PoHwer	-
Wandsworth	Advocacy Partners	-
Warrington	North West Advocacy Service	-
West Berkshire	MATRIX ADVOCACY SERVICE	-
West Sussex	Advocacy Partners	-
Wigan	Wigan Family Welfare	-
Windsor and Maidenhead	MATRIX ADVOCACY SERVICE	-
Wirral	Advocacy in Wirral	-
Wolverhampton	PoHwer	-
York	Cloverleaf Advocacy	-
None in the following:		
Bracknell Forest	Southend	0
Darlington	Harrow	0
Isles of Scilly	City of London	0
Northumberland	Rutland	0
Peterborough	Bexley	0

Local Authority	Organisation	No. referrals
Redcar & Cleveland	Walshall	0
Richmond Upon Thames	Rochdale	0
Sandwell	Gateshead	0
Thurrock		0
Wokingham	Slough	0
England	Totals	968

A dash (-) = less than 5 cases

Comparative tables from the IMCA Database

Table 1) Number of eligible and non-eligible referrals: comparison of 2 years

2007/2008				2008/2009			
Eligible		Non-Eligible	Total	Eligible		Non-Eligible	Total
Apr-07	219	120	339	Apr-08	567	200	767
May-07	349	179	528	May-08	561	193	754
Jun-07	388	191	579	Jun-08	579	191	770
Jul-07	428	204	632	Jul-08	619	195	814
Aug-07	448	162	610	Aug-08	544	152	696
Sep-07	428	193	621	Sep-08	557	147	704
Oct-07	539	209	748	Oct-08	676	158	834
Nov-07	532	206	738	Nov-08	545	143	688
Dec-07	386	181	567	Dec-08	504	130	634
Jan-08	544	232	776	Jan-09	558	93	651
Feb-08	472	171	643	Feb-09	462	89	551
Mar-08	446	109	555	Mar-09	410	54	464
Total	5179	2157	7336	Total	6582	1745	8327

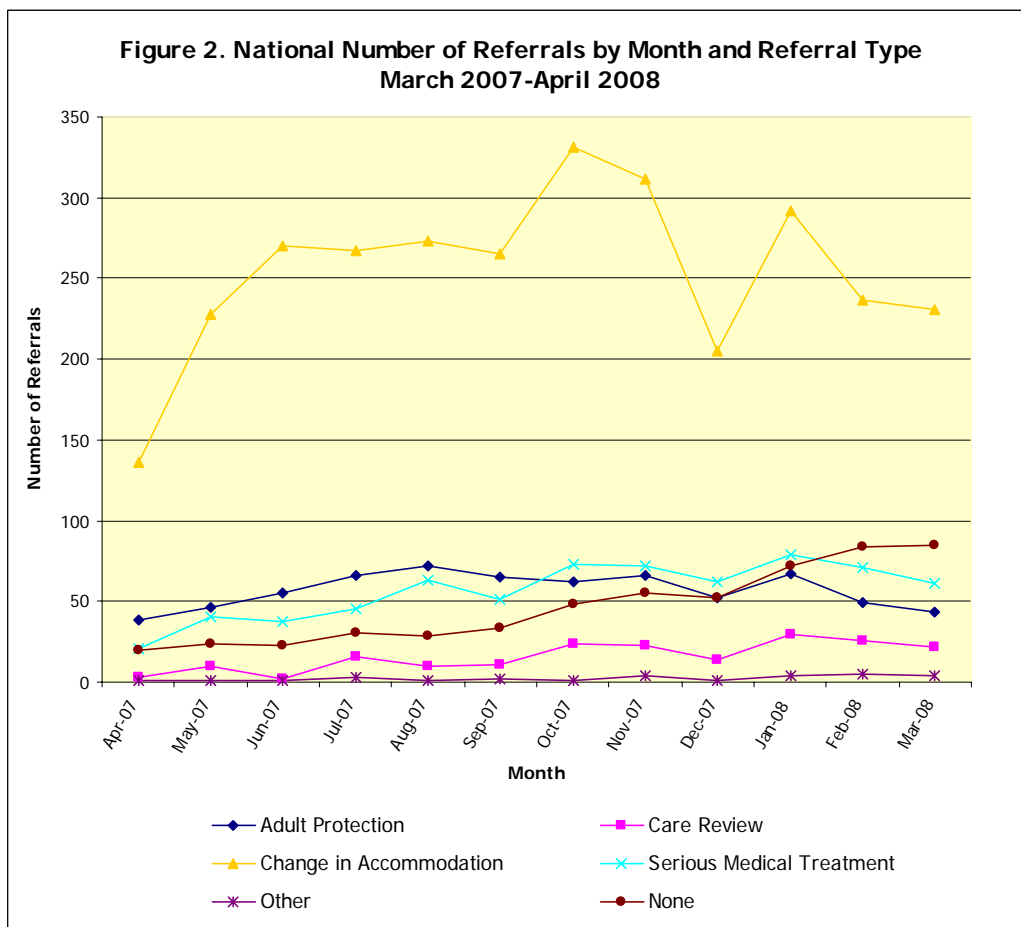
Table 2) Referral rates by decision type

2a) 2007/2008

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

2b) 2008/2009

	Adult Protection	Care Review	Change in Accommodation	in Serious Medical Treatment	Other	None	Total
Apr-08	61	18	366	81	-	40	567
May-08	82	33	320	78	-	47	561
Jun-08	73	32	322	104	-	45	579
Jul-08	102	49	341	88	-	35	619
Aug-08	89	37	281	78	-	55	544
Sep-08	85	29	296	87	-	56	557
Oct-08	112	53	344	93	-	71	676
Nov-08	98	38	287	71	-	50	545
Dec-08	85	16	270	73	-	57	504
Jan-09	62	44	255	87	6	104	558
Feb-09	59	15	248	64	-	76	462
Mar-09	52	23	166	64	-	103	410
Total	960	387	3496	968	32	739	6582
Percent	14.59	5.88	53.11	14.71	0.49	11.2	100



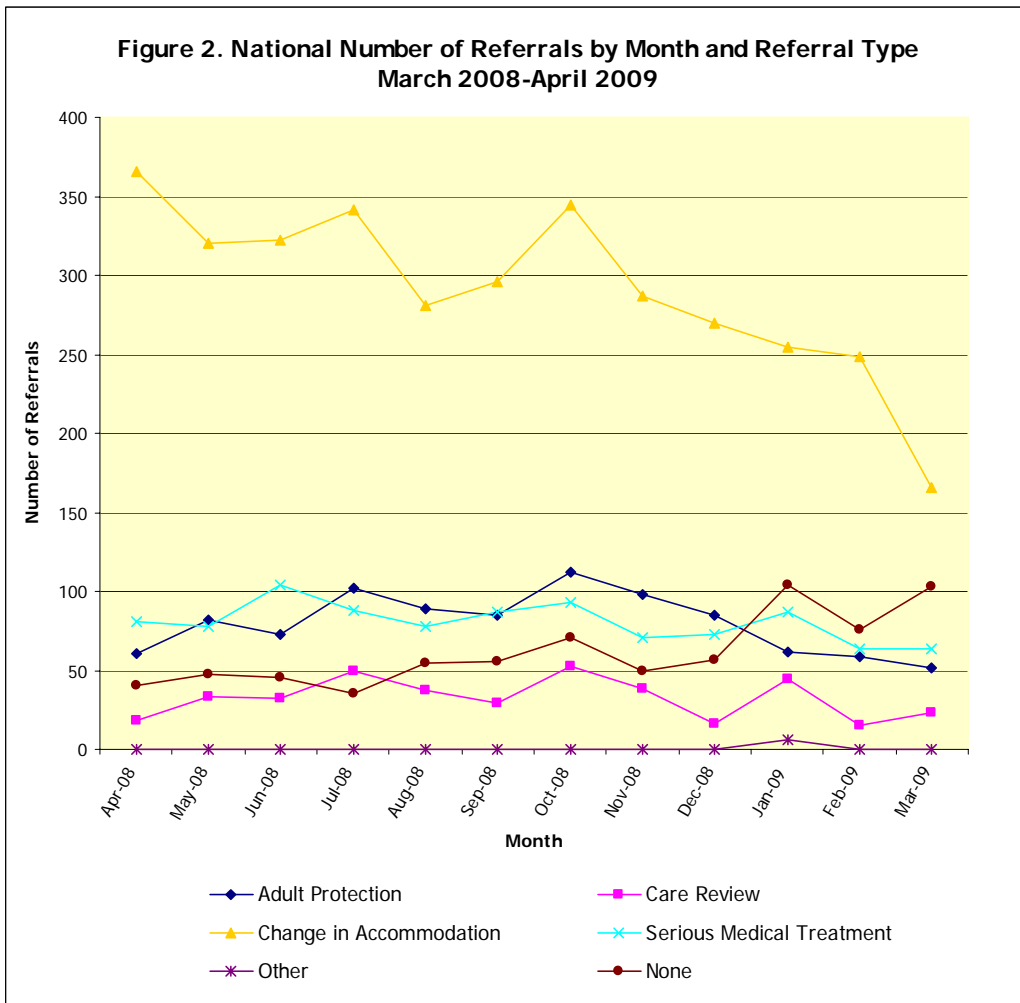


Table 3) Gender of Clients who received an IMCA service

3a) 2007/2008

		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	Unknown	Total	%	
2007/2008	Gender	Male	274	89	1430	11	336	259	2399	46.3
		Female	407	101	1613	17	339	294	2771	53.5
		Unknown		1	4			4	9	0.2
		Total	681	191	3047	28	675	557	5179	100.0

3b) 2008/2009

		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	Unknown	Total	%	
2008/2009	Gender	Male	328	187	1661	14	491	361	3042	46.2
		Female	632	198	1822	18	475	371	3516	53.4
		Unknown		2	13		2	7	24	0.4
		Total	960	387	3496	32	968	739	6582	100

Table 4) Age of Clients

4a) 2007/2008

			Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	Unknown	Total	%
2007/2008	Age	16 - 17	2		12			1	15	0.3
		18 - 30	82	11	93	2	37	31	256	4.9
		31 - 45	81	14	239	2	97	55	488	9.4
		46 - 65	138	43	683	5	226	142	1237	23.9
		66 - 79	130	45	797	9	149	127	1257	24.3
		80 and over	230	74	1141	10	142	140	1737	33.5
		Not known	18	4	82		24	61	189	3.6
		Total	681	191	3047	28	675	557	5179	100

4b) 2007/2008

			Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	Unknown	Total	%
2008/2009	Age	16 - 17	3	0	11	1	3	2	20	0.3
		18 - 30	90	17	120	1	34	30	292	4.4
		31 - 45	116	25	230	4	106	65	546	8.3
		46 - 65	179	77	710	7	379	183	1535	23.3
		66 - 79	196	112	901	10	227	170	1616	24.5
		80 and over	330	140	1394	6	181	207	2258	34.3
		Not known	46	16	130	3	38	82	315	4.8
		Total	960	387	3496	32	968	739	6582	100

Table 5) Ethnic background of Clients

5a) 2007/2008

		Adult Protection	Care Review	Change in Accom.	Other	Serious Medical Treatment	N/K	Total	%	
2007/2008	Ethnic Background	Not Specified	15	4	57		8	30	114	2.2
		White British	570	163	2518	26	563	434	4274	82.5
		White Irish	15	2	88		11	7	123	2.4
		White Other	16	9	117	1	20	18	181	3.5
		White + Black Caribbean	1		10		4	3	18	0.3
		White + Black African		1	8		2		11	0.2
		White + Asian	2		5		1	2	10	0.2
		Mixed White Other			4		1		5	0.1
		Asian British or Indian	7	3	15		3	4	32	0.6
		Asian British or Pakistani	10	3	15		1	6	35	0.7
		Asian British or Bangladeshi	4		8		1	3	16	0.3
		Other Asian	8		12		5		25	0.5
		Black British / Caribbean	4	1	63		18	11	97	1.9
		Black British / African	4		23	1	6	6	40	0.8
		Other Black	2		6		3		11	0.2
		Chinese	2	1	3		5		11	0.2
		Other Ethnic Category	3	1	19		6	4	33	0.6
Not Established	18	3	76		17	29	143	2.8		
Total	681	191	3047	28	675	557	5179	100		

5b) 2008/2009

		Adult Protection	Care Review	Change in Accom.	Other	Serious Medical Treatment	N/K	Total	%	
2008/2009	Ethnic Background	Not Specified	20	D/P	66	-	25	63	177	2.9
		White British	783	335	2941	28	815	568	5470	83.11
		White Irish	15	9	69	-	14	14	121	1.84
		White Other	27	8	140	D/P	23	21	221	3.36
		White + Black Caribbean	D/P	-	11	-	8	D/P	28	0.43
		White + Black African	D/P	-	D/P	-	D/P	-	6	0.09
		White + Asian	D/P	D/P	-	6	-	D/P	10	0.15
		Mixed White Other	-	-	-	6	-	D/P	7	0.11
		Asian British or Indian	20	D/P	-	24	8	7	63	0.96
		Asian British or Pakistani	16	D/P	20	D/P	-	-	43	0.65
		Asian British or Bangladeshi	D/P	-	9	-	-	-	14	0.21
		Other Asian	D/P	D/P	14	D/P	D/P	-	23	0.35
		Black British / Caribbean	22	9	78	-	18	13	140	2.13
		Black British / African	6	D/P	29	D/P	10	9	56	0.85
		Other Black	D/P	-	8	D/P	-	-	12	0.18
		Chinese	D/P	-	D/P	-	D/P	-	9	0.14
		Other Ethnic Category	8	D/P	18	D/P	D/P	-	38	0.58
Not Established	25	8	51	-	28	32	144	2.19		
Total	960	387	3496	32	968	739	6582	100		

Table 6) Nature of Impairment

6a) 2007/2008

			Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	N/K	Total	%
2007/2008	Nature of Client's Impairment	Acquired Brain Damage	45	9	150	1	27	21	253	4.9
		Autism Spectrum Condition	24	10	64	1	13	13	125	2.4
		Cognitive Impairment	45	16	229	1	27	37	355	6.9
		Combination	28	9	161	5	40	27	270	5.2
		Dementia	268	77	1272	10	129	163	1919	37.1
		Learning Disability	150	38	532	5	221	139	1085	20.9
		Mental Health Problems	72	19	385	4	104	74	658	12.7
		Not Specified	4	1	52		6	45	108	2.1
		Other	22	9	114		23	22	190	3.7
		Serious Physical Illness	23	3	87		64	14	191	3.7
		Unconsciousness			1	1	21	2	25	0.5
Total			681	191	3047	28	675	557	5179	100

6b) 2008/2009

			Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	N/K	Total	%
2008/2009	Nature of Client's Impairment	Acquired Brain Damage	45	11	155	-	42	34	285	4.3
		Autism Spectrum Condition	18	9	46	-	42	15	131	1.9
		Cognitive Impairment	88	31	347	-	43	63	577	8.7
		Combination	22	12	139	-	28	49	251	3.8
		Dementia	395	167	1425	7	155	233	2382	36.2
		Learning Disability	210	77	582	-	387	152	1413	21.5
		Mental Health Problems	106	46	497	-	106	98	858	13.0
		Not Specified	18	7	50	-	15	57	147	2.2
		Other	26	13	146	-	16	23	226	3.4
		Serious Physical Illness	32	14	107	-	103	14	273	4.1
		Unconsciousness	-	-	-	-	36	-	39	0.6
Total			960	387	3496	32	968	739	6582	100

Table 7) Location at time of decision

7a) 2007/2008

2007/2008	Place of residence at the time of referral	Not Specified			3		3	1	7	0.1
		Own Home	197	15	261	9	59	15	556	10.7
		Care Home	265	119	926	7	217	42	1576	30.4
		Hospital	126	38	1466	9	320	57	2016	38.9
		Supported L	35	7	162		39	10	253	4.9
		Uncertain	1		10		1		12	0.2
		Prison	1				3		4	0.1
		Other	29	5	148	1	14	12	209	4.0
		N/A	27	7	71	2	19	420	546	10.5
		Total	681	191	3047	28	675	557	5179	100

7b) 2008/2009

2008/2009	Place of residence at the time of referral	Not Specified	4	-	6	-	6	8	24	0.36
		Own Home	264	38	270	4	88	18	682	10.36
		Care Home	365	264	1077	13	337	42	2098	31.87
		Hospital	197	36	1745	12	398	61	2449	37.21
		Supported L	46	27	154	3	90	6	326	4.95
		Uncertain	10	-	10	-	8	-	28	0.43
		Prison	1	-	1	-	2	-	3	0.05
		Other	34	5	135	-	10	5	189	2.87
		N/A	39	17	98	-	29	599	782	11.88
		Total	960	387	3496	32	968	739	6582	100

Table 8) Decision Makers

8a) 2007/2008

2007/2008		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	None	Total	%
	Doctor	19	26	270	5	478	23	821	15.9
	Social Worker	538	126	2202	17	51	87	3021	58.3
	Other	94	31	497	4	123	20	769	14.8
	Unknown	30	8	78	2	23	427	568	11.0
Total	681	191	3047	28	675	557	5179	100	

8b) 2008/2009

2008/2009		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	None	Total	%
	Doctor	27	22	230	10	746	22	1057	16.1
	Social Worker	760	289	2636	9	37	89	3820	58.0
	Other	125	56	510	13	148	18	870	13.2
	Unknown	48	17	120	-	37	610	835	12.7
Total	960	387	3496	32	968	739	6582	100	

Table 9) Accommodation referrals

		2007/2008		2008/2009	
From:	To:	Count	%	Count	%
Own Home	Own Home	3	0.4	4	0.52
	Care Home	472	69.5	466	60.99
	Hospital	4	0.6	7	0.92
	Supported Living	37	5.4	34	4.45
	TBC	150	22.1	243	31.81
	Other	13	1.9	9	1.18
	Not specified	-	-	1	0.13
	Total	679	100	764	100
Care Home	Own Home	49	5.7	34	4.23
	Care Home	552	64.3	572	58.25
	Hospital	2	0.2	2	1.02
	Supported Living	57	6.6	53	2.63
	TBC	188	21.9	274	31.75
	Other	11	1.3	26	1.68
	Not specified	-	-	3	0.44
	Total	859	100	964	100
Hospital	Own Home	41	3.5	58	4.23
	Care Home	764	65.6	798	58.25
	Hospital	14	1.2	14	1.02
	Supported Living	38	3.3	36	2.63
	TBC	289	24.8	435	31.75
	Other	19	1.6	23	1.68
	Not specified	-	-	6	0.44
	Total	1165	100	1370	100
Supported Living	Own Home	3	1.5	6	3.02
	Care Home	75	38.1	76	38.19
	Supported Living	55	27.9	66	33.17
	TBC	56	28.4	46	23.12
	Other	8	4.1	4	2.01
	Not specified	-	-	0	0
	Total	197	100	199	100
Other	Own Home	8	6.4	4	2.65
	Care Home	46	36.8	52	34.44
	Hospital	1	0.8	0	0
	Supported Living	16	12.8	17	11.26
	TBC	39	31.2	63	41.72
	Other	15	12.0	14	9.27
	Not specified	-	-	1	0.66
	Total	125	100	151	100
Prison	TBC	1	100	1	100
Unknown	Unknown	21	100	-	-
	Totals	3047	100	3449	100

Table 10) Numbers of Care Reviews

	2007/2008		2008/2009	
	Count	%	Count	%
Open	80	41.9	162	41.86
Closed	111	58.1	225	58.14
Total	191	100.0	387	100.00

Table 11) Serious Medical Treatment Referrals

11a) 2007/2008

		Open	Closed	Total Count	%
		2007/2008	Affecting Hearing/Sight	3	7
ANH	6		10	16	2.4
Cancer Treatment	40		30	70	10.4
DNAR	26		37	63	9.3
ECT	2			2	0.3
Hip / Leg Operation	9		16	25	3.7
Major Amputations	2		6	8	1.2
Major Surgery	21		17	38	5.6
Medical Investigations	41		66	107	15.9
Not Specified	29		18	47	7.0
Other	113		139	252	37.3
Pregnancy Termination			4	4	0.6
Serious Dental Work	12		21	33	4.9
Total	304		371	675	100

11b) 2007/2008

		Open	Closed	Total Count	%
		2008/2009	Affecting Hearing/Sight	2	13
ANH	6		19	25	2.58
Cancer Treatment	27		54	81	8.37
DNAR	24		85	109	11.26
ECT	No		Records	No	Records
Hip / Leg Operation	9		14	23	2.38
Major Amputations	1		9	10	1.03
Major Surgery	17		22	39	4.03
Medical Investigations	52		111	163	16.84
Not Specified	34		39	73	7.54
Other	90		234	324	33.47
Pregnancy Termination	1		0	1	0.10
Serious Dental Work	31		74	105	33.47
Total	294		674	968	100.00

Table 12) Number of adult protection cases

	2007/2008		2008/2009	
	Count	%	Count	%
Open	268	39.4	455	47.4
Closed	413	60.6	505	52.6
Total	681	100.0	960	100.0

Table 13) How well the LA / NHS worked with the IMCAs

13a) 2007/2008

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2007/2008	Very Well	192	61	879	6	236	36	1410	45.0
	Well	144	40	717	5	167	52	1125	35.9
	Not Well	37	6	204	2	44	9	302	9.6
	Unknown	40	4	183		42	30	299	9.5
	Total	413	111	1983	13	489	127	3136	100.0

13b) 2007/2008

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	Not Specified	40	10	167	7	39	13	276	7.39
	Very Well	296	155	1438	10	426	50	2375	63.57
	Well	165	57	574	6	200	27	1029	27.54
	Not Well	2		15		3	1	21	0.56
	Unknown	2	3	19		6	5	35	0.94
	Total	505	225	2213	23	674	96	3736	100.00

Table 14) How well IMCAs worked with the LA / NHS 2008/9

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

Table 15) Was the IMCA able to ascertain wishes?

15a) 2007/2008

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2007/2008	Able to Ascertain Client's Wishes	256	75	1417	9	250	69	2076	56.9
	Unable to Ascertain Client's Wishes	148	34	525	4	231	44	986	40.7
	None	9	2	41		8	14	74	2.4
	Total	413	111	1983	13	489	127	3136	100

15b) 2008/2009

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	Able to Ascertain Client's Wishes	324	164	1571	15	335	58	2467	66.0
	Unable to Ascertain Client's Wishes	179	58	623	8	333	33	1234	33.0
	None	-	-	19		6	-	35	0.9
	Total	505	225	2213	23	674	96	3736	100

Table 16) Did the decision reflect the client's wishes?

16a) 2007/2008

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2007/2008	Decision Reflects Client's Wishes	214	57	1071	7	235	65	1649	52.6
	Decision Does Not Reflect Client's Wishes	32	11	200	1	22	6	272	8.7
	Decision Reflects Client's Wishes Partly/Can't Tell	158	41	671	5	224	42	1141	36.4
	None	9	2	41		8	14	74	2.4
	Total	413	111	1983	13	489	127	3136	100

16b) 2008/2009

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	Decision Reflects Client's Wishes	231	122	1059	12	251	42	1717	69.6
	Decision Does Not Reflect Client's Wishes	14	10	156	-	12	-	194	7.9
	Decision Reflects Client's Wishes Partly/Can't Tell	79	32	356	-	72	14	556	22.5
	None	-	-	-	-	-	-	-	-
	Total	324	164	1571	15	335	58	2467	100

Table 17) Was the Outcome Significantly Affected by the IMCA involvement?

17a) 2007/2008

		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	None	Total	%
2007/2008	Outcome Significantly Affected By IMCA Involvement	260	55	1149	7	247	66	1784	56.9
	Outcome Not Significantly Affected By IMCA Involvement	144	54	793	6	233	47	1277	40.7
	None	9	2	41	-	9	14	75	2.4
	Total	413	111	1983	13	489	127	3136	100

17b) 2008/2009

		Adult Protection	Care Review	Change in Accomm.	Other	Serious Medical Treatment	None	Total	%
2008/2009	Outcome Significantly Affected By IMCA Involvement	293	119	1237	12	369	47	2077	55.6
	Outcome Not Significantly Affected By IMCA Involvement	210	103	957	11	299	44	1624	43.5
	None	2	3	19	-	6	5	35	0.9
	Total	505	225	2213	23	674	96	3736	100

Table 18) Did the IMCA challenge the decision?

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	IMCA Challenged Decision	61	21	258	9	75	16	440	11.8
	IMCA Didn't Challenged Decision	442	201	1936	14	593	75	3261	87.3
	None	-	-	19	-	6	-	35	0.9
	Total	505	225	2213	23	674	96	3736	100

Table 19) Overall Satisfaction with the Case (Closed Cases Only)

		Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	Very Satisfied	220	119	1084	6	341	35	1805	48.3
	Quite Satisfied	163	68	696	7	197	29	1160	31.0
	Not Satisfied	48	10	150	1	58	12	279	7.5
	Unknown	74	28	283	9	78	20	492	13.1

Table 20) Hours Spent on Each Case

In many cases zero hours were recorded for eligible referrals. The impact of this is to bring the average down.

20a) 2007/2008

		Total Hours With Client	Total Hours Consulting Others	Total Hours Obtaining Reviewing	Total Hours Report Writing	Total Hours Travelling	Total Hours Attending Decision Making Meetings	Total Hours Other	Total Hours On Each Case
2007/2008	Adult Protection	1.10	1.97	1.05	1.57	2.09	1.08	0.71	9.99
	Care Review	0.61	1.12	0.56	0.98	1.49	0.60	0.42	6.17
	Change in Accommodation	0.98	2.13	1.21	1.64	1.97	0.45	0.67	9.57
	Other	0.67	2.59	0.80	1.63	1.55	0.24	0.97	8.97
	Serious Medical Treatment	0.61	1.71	0.97	1.43	1.22	0.38	0.57	7.31
	All Referrals	0.88	1.92	1.08	1.50	1.77	0.51	0.63	8.76

20b) 2008/2009

		Total Hours With Client	Total Hours Consulting Others	Total Hours Obtaining Reviewing	Total Hours Report Writing	Total Hours Travelling	Total Hours Attending Decision Making Meetings	Total Hours Other	Total Hours On Each Case
2008/2009	Adult Protection	0.89	2.21	1.09	1.59	1.83	1.06	0.59	9.27
	Care Review	0.84	1.65	1.07	1.57	1.80	1.29	0.44	8.66
	Change in Accommodation	1.25	2.73	1.88	2.16	1.97	0.74	0.78	11.51
	Other	0.45	1.54	1.74	1.25	0.61	0.13	0.13	5.84
	Serious Medical Treatment	1.18	3.72	2.06	2.58	2.40	0.97	2.25	15.16
	All Referrals	1.15	2.77	1.75	2.12	2.01	0.86	1.00	11.66

Table 21) Report written?

21a) 2007/2008

	Was a report submitted?	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2007/2008	No	396	126	1407	17	301	481	2728	52.7
	Yes	285	65	1640	11	374	76	2451	47.3
	Total	681	191	3047	28	675	557	5179	100

21b) 2008/2009

	Was a report submitted?	Adult Protection	Care Review	Change in Accommodation	Other	Serious Medical Treatment	None	Total	%
2008/2009	No	214	86	782	15	240	51	1388	37.1
	Yes	291	139	1431	8	434	45	2348	62.8
	Total	505	225	2213	23	674	96	3736	100

Table 22) Full Rankings of Authorities: IMCA Referrals

April 2007 – March 2008					April 2008 – March 2009				
Rank	Authority	Eligible	Not Eligible	Total	Authority	Eligible	Not Eligible	Total	
1	NORFOLK	168	20	188	SURREY	179	28	207	
2	WEST SUSSEX	163	30	193	CORNWALL	175	16	191	
3	SUFFOLK	133	47	180	MANCHESTER	164	70	234	
4	CORNWALL	128	44	172	LEEDS	160	41	201	
5	MANCHESTER	116	64	180	KENT	138	11	149	
6	SURREY	114	5	119	BIRMINGHAM	130	50	180	
7	LEEDS	113	3	116	SUFFOLK	128	40	168	
8	LANCASHIRE	110	160	270	HAMPSHIRE	125	101	226	
9	ESSEX	104	12	116	DEVON	121	86	207	
10	KENT	93	30	123	NORFOLK	121	11	132	
11	GLOUCESTERSHIRE	91	8	99	ESSEX	117	22	139	
12	CAMBRIDGESHIRE	87	78	165	HERTFORDSHIRE	111	2	113	
13	CHESHIRE	79	35	114	GLOUCESTERSHIRE	108	1	109	
14	BIRMINGHAM	75	51	126	LANCASHIRE	108	104	212	
15	STAFFORDSHIRE	75	32	107	BRISTOL UA	100	19	119	
16	HERTFORDSHIRE	73	13	86	LINCOLNSHIRE	98	7	105	
17	BRISTOL UA	73	19	92	LIVERPOOL	98	39	137	
18	CUMBRIA	72	54	126	SHEFFIELD	93	23	116	
19	NOTTINGHAMSHIRE	66	1	67	WEST SUSSEX	90	31	121	
20	HAMPSHIRE	59	129	188	DERBYSHIRE	84	15	99	
21	PLYMOUTH UA	59	10	69	NORTH YORKSHIRE	83	6	89	
22	DORSET	58	11	69	KIRKLEES	82	58	140	
23	LIVERPOOL	57	46	103	STAFFORDSHIRE	80	29	109	
24	SUTTON	57	8	65	CAMDEN	77	13	90	
25	CAMDEN	55	14	69	CUMBRIA	76	8	84	
26	EAST SUSSEX	55	15	70	SOMERSET	76	7	83	
27	LAMBETH	54	22	76	DORSET	73	3	76	
28	WESTMINSTER	54	15	69	BARKING & DAGENHAM	71	21	92	
29	WALTHAM FOREST	51	4	55	LAMBETH	69	9	78	
30	BARNET	50		50	BRADFORD	66	26	92	
31	SOMERSET	49	36	85	CAMBRIDGESHIRE	64	39	103	
32	CROYDON	48	25	73	PLYMOUTH UA	64	3	67	
33	TOWER HAMLETS	47	14	61	CHESHIRE	60	26	86	
34	BRIGHTON & HOVE	46	15	61	EAST SUSSEX	60	18	78	
35	NORTH YORKSHIRE	45	9	54	HAVERING	60	34	94	
36	ENFIELD	44	1	45	WAKEFIELD	59	54	113	

April 2007 – March 2008

April 2008 – March 2009

Rank	Authority	Eligible	Not Eligible	Total	Authority	Eligible	Not Eligible	Total
37	WIGAN	43	15	58	LEICESTER UA	56	2	58
38	WANDSWORTH	42	18	60	WARWICKSHIRE	56	7	63
39	BOURNEMOUTH	42	17	59	NOTTINGHAMSHIRE	55	12	67
40	SEFTON	41	23	64	ENFIELD	54	4	58
41	ISLINGTON	41	12	53	TORBAY UA	53	16	69
42	WIRRAL	40	2	42	WALTHAM FOREST	52		52
43	DERBYSHIRE	39	36	75	STOCKPORT	50	6	56
44	LEICESTER UA	39	8	47	STOKE-ON-TRENT UA	50	29	79
45	YORK UA	38	4	42	BOURNEMOUTH UA	48	1	49
46	SOUTHWARK	37	6	43	BATH & NORTH EAST SOMERSET UA	47	6	53
47	BATH & NORTH EAST SOMERSET UA	37	11	48	TAMESIDE	47	8	55
48	DEVON	36	109	145	WORCESTERSHIRE	47	6	53
49	TORBAY UA	36	39	75	DERBY UA	46	13	59
50	LINCOLNSHIRE	35	15	50	CROYDON	45	7	52
51	WILTSHIRE	35	23	58	OXFORDSHIRE	45	12	57
52	TAMESIDE	33	21	54	WANDSWORTH	44	18	62
53	NORTHAMPTONSHIRE	33	35	68	DURHAM	43	5	48
54	DURHAM	32	9	41	SEFTON	43	16	59
55	SHEFFIELD	32	10	42	SUNDERLAND	43	11	54
56	KIRKLEES	32	1	33	BARNET	42	9	51
57	WARWICKSHIRE	32	8	40	NORTH SOMERSET UA	42	34	76
58	WORCESTERSHIRE	32	13	45	KENSINGTON & CHELSEA	41		41
59	OXFORDSHIRE	32	4	36	SWINDON UA	41		41
60	DONCASTER	31	5	36	WIGAN	41	14	55
61	SALFORD	31	2	33	NOTTINGHAM UA	40	1	41
62	NOTTINGHAM UA	31	1	32	NORTHAMPTONSHIRE	39	26	65
63	LEWISHAM	31	7	38	SOUTHAMPTON UA	39	8	47
64	STOKE-ON-TRENT UA	30	25	55	SALFORD	37	5	42
65	BUCKINGHAMSHIRE	30	10	40	YORK UA	36	1	37
66	KINGSTON UPON THAMES	30		30	ISLINGTON	35	12	47
67	REDBRIDGE	30	12	42	KINGSTON UPON THAMES	35	6	41
68	BARNLEY	29	3	32	WILTSHIRE	35	9	44
69	BROMLEY	29	5	34	LEWISHAM	34	5	39
70	POOLE UA	28	7	35	NEWHAM	34	3	37
71	WAKEFIELD	27	3	30	WESTMINSTER	34	3	37
72	MILTON KEYNES UA	27	3	30	LEICESTERSHIRE	33	2	35

April 2007 – March 2008

April 2008 – March 2009

Rank	Authority	Eligible	Not Eligible	Total	Authority	Eligible	Not Eligible	Total
73	NEWCASTLE UPON TYNE	26	6	32	WIRRAL	33	6	39
74	LEICESTERSHIRE	26	2	28	BROMLEY	32	3	35
75	KENSINGTON & CHELSEA	26	12	38	HARINGEY	32	7	39
76	NEWHAM	26	9	35	PORTSMOUTH UA	32	16	48
77	BLACKPOOL UA	25	22	47	SOUTH TYNESIDE	32	8	40
78	KINGSTON UPON HULL UA	24	3	27	TOWER HAMLETS	32	11	43
79	ST HELENS	24	1	25	SOUTHWARK	31	5	36
80	DUDLEY	24	5	29	COVENTRY	30	2	32
81	PORTSMOUTH UA	24	12	36	ROCHDALE	30	5	35
82	OLDHAM	23	6	29	WARRINGTON UA	30	2	32
83	BLACKBURN WITH DARWEN UA	23	26	49	HAMMERSMITH & FULHAM	29		29
84	PETERBOROUGH UA	23	27	50	POOLE UA	29	1	30
85	BOLTON	22	3	25	BEDFORDSHIRE	27	3	30
86	STOCKPORT	22	10	32	BRIGHTON & HOVE UA	27	9	36
87	BEDFORDSHIRE	22	9	31	BUCKINGHAMSHIRE	27	3	30
88	READING UA	22	9	31	CALDERDALE	27	2	29
89	SOUTHAMPTON UA	22	21	43	EALING	27		27
90	NORTH SOMERSET UA	22	29	51	OLDHAM	27	8	35
91	EAST RIDING OF YORKSHIRE UA	21	11	32	EAST RIDING OF YORKSHIRE UA	25	6	31
92	SUNDERLAND	20	11	31	NEWCASTLE UPON TYNE	25	4	29
93	CALDERDALE	19	8	27	SOUTH GLOUCESTERSHIRE UA	25	20	45
94	ROCHDALE	19	6	25	BARNSELY	24	4	28
95	WARRINGTON UA	19	5	24	ISLE OF WIGHT UA	24	3	27
96	HACKNEY	19	1	20	SHROPSHIRE	24	3	27
97	RICHMOND UPON THAMES	19	2	21	BLACKBURN WITH DARWEN UA	23	13	36
98	COVENTRY	18		18	BRENT	23	3	26
99	DERBY UA	18	26	44	HEREFORDSHIRE UA	23	4	27
100	SOUTHEND UA	18	3	21	MILTON KEYNES UA	23	5	28
101	GREENWICH	18	4	22	NORTH TYNESIDE	23	4	27
102	BARKING & DAGENHAM	18	25	43	BURY	22	12	34
103	HOUNSLOW	18	4	22	RICHMOND UPON THAMES	22	7	29
104	SOUTH GLOUCESTERSHIRE UA	18	29	47	DONCASTER	21	10	31
105	DARLINGTON UA	17	1	18	ROTHERHAM	21	6	27

April 2007 – March 2008

April 2008 – March 2009

Rank	Authority	Eligible	Not Eligible	Total	Authority	Eligible	Not Eligible	Total
106	NORTH LINCOLNSHIRE UA	17	2	19	HARROW	20	2	22
107	MIDDLESBROUGH UA	16	3	19	READING UA	20	10	30
108	BRADFORD	16	14	30	SUTTON	20	11	31
109	SANDWELL	16	19	35	GREENWICH	19		19
110	NORTH TYNESIDE	15	2	17	NORTH LINCOLNSHIRE UA	19	1	20
111	HARTLEPOOL UA	15	1	16	TRAFFORD	19	5	24
112	SLOUGH UA	15	1	16	DUDLEY	18	6	24
113	HARINGEY	15	4	19	KINGSTON UPON HULL UA	18		18
114	CARDIFF UA	14	3	17	MEDWAY TOWNS UA	18	2	20
115	NORTHUMBERLAND	14	3	17	MIDDLESBOROUGH UA	18	2	20
116	KNOWSLEY	14	2	16	TELFORD & WREKIN UA	18	4	22
117	BRENT	14	5	19	WOLVERHAMPTON	18	5	23
118	MEDWAY TOWNS UA	14	3	17	HARTLEPOOL UA	17	7	24
119	SOUTH TYNESIDE	13	9	22	HILLINGDON	17	2	19
120	BURY	13	8	21	KNOWSLEY	17	4	21
121	WOLVERHAMPTON	13	12	25	REDBRIDGE	17	13	30
122	GATESHEAD	12	3	15	BLACKPOOL UA	16	17	33
123	HEREFORDSHIRE UA	12	4	16	HACKNEY	16	2	18
124	TELFORD & WREKIN UA	12	3	15	MERTON	16	2	18
125	HAMMERSMITH & FULHAM	12	4	16	SANDWELL	16	9	25
126	MERTON	12	3	15	HOUNSLOW	15	4	19
127	HAVERING	11	29	40	LUTON UA	15		15
128	HALTON UA	10	1	11	SOLIHULL	15	2	17
129	WINDSOR & MAIDENHEAD UA	10	1	11	BOLTON	14	4	18
130	EALING	10	4	14	SOUTHEND UA	14	3	17
131	ISLE OF WIGHT UA	10	11	21	DARLINGTON UA	13	3	16
132	REDCAR & CLEVELAND UA	9	3	12	HALTON UA	12	2	14
133	ROTHERHAM	9	4	13	NORTH EAST LINCOLNSHIRE UA	12		12
134	SOLIHULL	9		9	NORTHUMBERLAND	12	1	13
135	SHROPSHIRE	9	4	13	BEXLEY	11	4	15
136	BRACKNELL FOREST UA	9		9	PETERBOROUGH UA	11	10	21
137	STOCKTON ON TEES UA	7	1	8	ST HELENS	10		10
138	TRAFFORD	7	3	10	WEST BERKSHIRE UA	10	3	13
139	HARROW	7	1	8	BRACKNELL FOREST	8		8

April 2007 – March 2008					April 2008 – March 2009			
Rank	Authority	Eligible	Not Eligible	Total	Authority	Eligible	Not Eligible	Total
					UA			
140	SWINDON UA	7	9	16	GATESHEAD	7	1	8
141	HILLINGDON	6	4	10	SLOUGH UA	7	5	12
142	BEXLEY	5	3	8	STOCKTON ON TEES UA	7	1	8
143	NORTH EAST LINCOLNSHIRE UA	4	3	7	WOKINGHAM UA	6	2	8
144	THURROCK UA	4	14	18	WALSALL	5	7	12
145	WALSALL	3	6	9	REDCAR & CLEVELAND	-	1	-
146	LUTON UA	3	1	4	RUTLAND UA	-	-	-
147	WOKINGHAM UA	1	0	1	THURROCK UA	-	1	-
148	RUTLAND UA	0	0	0	WINDSOR & MAIDENHEAD UA	-	-	-
149	ISLES OF SCILLY	0	0	0	CITY OF LONDON	0	0	0
150	CITY OF LONDON	0	0	0	ISLES OF SCILLY	0	0	0
	Total	5273	2210	7483	Total	6582	1745	8327

A dash (-) signifies between 1-5 referrals.

APPENDIX 2: RESEARCH ON VIEWS ON THE SECOND YEAR, BY CARYS BANKS AND MARCUS REDLEY, CAMBRIDGE UNIVERSITY

IMCAs in their Second Year: The experience of key stakeholders 2009

This is a report commissioned by the Social Care Institute for Excellence and the Department of Health, and prepared by Carys Banks and Marcus Redley, supported by Isabel Clare and Tony Holland, at the Department of Psychiatry, University of Cambridge.

Introduction

The stakeholder experiences reported here come from semi-structured interviews with: (i) ten managers from organizations providing IMCA services; (ii) ten local authority Commissioners of IMCA services; (iii) nine hospital based MCA leads; and (iv) ten local authority MCA leads. All the interviews were conducted over the telephone and answers were recorded by hand. No individual respondent's answers are identifiable in this report as they were all assured of anonymity for themselves and their organizations. Ten IMCA provider organizations supported the research (see Table below), giving contact details for 10 respondents in each of the follow groups: 1) hospital based MCA Leads; 2) local authority Commissioners of IMCA services; and 3) local authority MCA leads.

The Ten IMCA provider organisations providing IMCA services:

Advocacy Experience
Advocacy Partners
Kingston Advocacy Group (KAG)
Leeds Advocacy
Oxfordshire Advocacy
POhWER
Rethink
Eclipse
South of England Advocacy Project (SEAP)
Speaking Up

This report first presents experiences from the different stakeholders and then offers some points for consideration.

Stakeholder Experiences

This part of the report is divided into 4 sections. The first section reports findings from our interviews with ten local authority Commissioners responsible for IMCA services; the second presents findings from our interviews with the managers of the individual provider organisations; section three discusses the views of MCA leads in hospitals; and section four considers the perspectives of MCA leads in local authorities.

1. Commissioning an IMCA service

All the Commissioners we spoke to were happy with the service they were receiving, with some respondents specifically praising IMCAs' knowledge of their role and the Mental Capacity Act (MCA). When asked to identify the particular strengths of their IMCA service provider, Commissioners highlighted the following:

- The speed with which many IMCAs responded to referrals,
- The links that provider organisations were building with local authorities and generic (non-IMCA) advocacy services,
- The effort IMCA provider organisations had taken to promote their service in health and social care, and
- The dedication and competence of individual IMCAs.

When asked about possible improvements to their IMCA service, Commissioners mentioned the need for the following:

- IMCAs to be more available,
- Improved communication with healthcare professionals, and
- Better engagement with BME populations.

Almost all the Commissioners were concerned about the under utilization of the service and the impact this had on the cost effectiveness of the IMCA service. Competitive tendering for IMCA services was thought to be beneficial in that it:

- Offered best value for money,
- Excluded would-be IMCA provider organisations that lacked a secure financial and/or managerial base,
- Provided the local authority with the necessary leverage to specify contractual terms for delivering an IMCA service, and
- Greatly increased the pool of organisations bidding to provide an IMCA service.

All the local authorities were monitoring the quality of the IMCA service they received by holding steering groups (meeting half yearly, quarterly, or bi-monthly) and asking for statistics documenting the number and type (for example, serious medical treatment or change of accommodation) of IMCA cases. Ensuring the quality of IMCA services was, however, thought to be problematic. There were thought to be difficulties in getting useful information about the service from clients, and decision-makers were often reluctant to fill-in satisfaction monitoring forms. One Commissioner told us that only 15% of decision-makers asked to complete a satisfaction form had responded. Two other Commissioners told us they were using IMCA attendance at training events and average time taken to respond to referrals as measures of quality.

Asked about informal and unsolicited feedback from health and social care practitioners, two Commissioners told us they had received complaints about their IMCA service. These were, however, seen as early teething troubles. Another Commissioner had responded to complaints by social care practitioners about **the time it took IMCAs to deliver reports** by making this a performance indicator. Where feedback from health and social care practitioners was positive, this was

usually couched in terms of good communication between IMCAs and decision-makers. Some Commissioners told us they also had received complaints from IMCA providers about decision-makers' lack of understanding of the MCA and the role of an IMCA.

1.1 The joint commissioning of IMCA services

Eight of the Commissioners we interviewed jointly commissioned their IMCA service with at least one other local authority. Of these eight joint commissioning arrangements, six involved joint staff training and awareness-raising in both health and social care, and also joint monitoring of the service. Joint commissioning was thought by those adopting it to be not only cost effective but also to lead to increased robustness in the provider organisations, thereby ensuring a better service for clients and one that was regionally more consistent. The only problem identified with joint commissioning apparently occurred when an individual local authority acted unilaterally to address specifically local issues. IMCA managers who were party to joint commissioning arrangements reported that the success and strength of these arrangements lay in good communication within steering groups.

2. Managing an IMCA service

The managers of IMCA services describe their successes in terms of the support they had provided to vulnerable adults lacking capacity and the improved public profile of advocacy. Their successes in these two domains had, they thought, contributed to an improvement in the image and confidence of advocates and advocacy organizations. With respect to supporting vulnerable adults they specifically mentioned:

- Protecting the decision-making of elderly people erroneously thought to have lacked capacity,
- Ensuring that decisions made on behalf of men and women lacking capacity reflected their interests and wishes,
- Seeing decisions changed better to reflect people's interests and wishes, and
- Promoting the voices and legal rights of vulnerable adults.

In terms of the improved public profile of advocacy and advocacy organisations the managers mentioned:

- Gaining local authority contracts for a statutory service,
- Being taken seriously by decision-makers in health and social care, and
- Being witnesses to a greater public awareness of advocacy.

With respect to success in these two arenas, two managers pointed to improvements in job satisfaction and self-esteem.

The managers, when asked about the average number of referrals per month, gave contrasting figures. The majority of managers were far from reaching the capacity of their services. Two managers, whose services were close to capacity, were not overly worried as fluctuations meant that currently high levels of demand were likely to be temporary. Another manager, currently also experiencing high levels of demand, said she was diverting staff away from awareness raising events. Though

these were important for her organization, she considered it necessary in order to meet the increased number of referrals. Two managers were concerned that the Deprivation of Liberty Safeguards would, at some point, lead to a significant increase in demand for IMCA services, thus diverting their efforts away from IMCA cases involving changes of accommodation and serious medical treatment.

The IMCA managers we spoke to saw a need for both regular and specialist IMCA training. There was a need for regular training to keep IMCAs focused, so that they had the confidence to remind decision-makers of their legal responsibilities and to withdraw from a case once a decision was made. Additional specialist training was thought appropriate with respect to the following:

- Adult Safeguarding,
- The criminal justice system, as IMCAs were being involved in court proceedings, and
- Healthcare, in light of the problems IMCAs were facing in securing referrals from healthcare practitioners.

Regional IMCA networks were identified as providing useful training opportunities although experiences were mixed. One manager said that these meetings had been particularly helpful in honing IMCAs' report writing skills while two others reported that the meetings had been poorly run. The advanced IMCA training was described as disappointing by one manager, while another said staff members felt let down when the advanced IMCA training was cancelled. Two managers mentioned the need for extra training on how adult services worked and on Adult Safeguarding.

IMCA managers told us that, even after two years, some decision-makers still failed to understand even the basics of the service, such as:

- That IMCAs do not themselves make decisions,
- That capacity assessments can be done by decision-makers themselves, making it unnecessary to involve either a psychiatrist or a clinical psychologist,
- The conditions under which it is appropriate to involve family members in the decision-making process,
- When an Adult Safeguarding case can become a statutory IMCA case if a client has family or friends who can represent their wishes,
- That decision-makers should keep IMCAs informed of developments in a case and not leave advocates casting round for information, and
- A failure to understand that statutory advocacy is decision-specific and can only be used for certain life-changing decisions.

Reflecting on the IMCA service in general, managers were asked if there was anything they specifically wanted to communicate to the Department of Health. Answers to this question varied but there did seem to be some overlapping areas of concern, for instance:

- That funding for the IMCA service might be reduced to reflect actual rather than anticipated demand,
- That to some IMCA managers, inviting tenders for a statutory service undermined the perceived worth of that service, and
- That in the current economic climate, local authorities might seek to reduce their spend on this service. This was particularly worrisome for one IMCA

manager because the cases in that service regularly took more time than the illustrative eight hours mentioned in the Department of Health's (2005) consultation.

Two IMCA managers were concerned about the national database, noting that it was difficult to use, and did not correspond either to provider organisation's own databases, or those being used by local authorities. In addition, one manager was concerned about those adults assumed to have capacity but who did not and were therefore not judged eligible for the services of an IMCA. With respect to IMCAs in the health service, two managers expressed concerns over the failure of healthcare practitioners to refer patients and expressed concerns that, in the absence of any penalties, decision-makers were, with impunity, failing to fulfil their statutory duties. Furthermore, understanding of the statutory duty to involve an IMCA in serious medical treatment decisions was generally considered to be inadequate. Many managers reported that high quality training materials were available; it was just that healthcare practitioners were not reading them. However, one manager sounded a positive note by suggesting that, over time, this situation would change.

2.1 IMCA managers' experiences of independent advocacy in the health service

The number of referrals from hospitals was invariably described as low. In a few instances, referral numbers were increasing slightly but without any noticeable rise in the proportion for serious medical treatment decisions. Explanations for the low level of demand included the following:

- The belief that IMCAs could not respond quickly enough for the types of decisions that needed to be made in healthcare settings,
- The belief that involving an IMCA would slow down the decision-making process.

In addition, and somewhat paradoxically, IMCA managers were of the opinion that healthcare practitioners had little knowledge of advocacy or of their duties under the MCA. One manager was of the opinion that a single healthcare practitioner could, if in his or her experience using an IMCA had been unhelpful, have a negative influence on the attitudes of all practitioners in that hospital. Where there had been a small increase in the number of referrals coming from healthcare settings, this was attributed to three factors:

- Awareness raising and training events,
- Situations in which care homes had alerted the IMCA service that an eligible person had been admitted to hospital, so that the advocate could then contact the prospective decision-maker and remind him or her of the MCA; and
- The development of relationships between IMCAs and individual healthcare practitioners, as a result of which there was a better and more sympathetic understanding of the service.

3. The views of hospital MCA leads

All the hospital-based MCA leads, while acknowledging that the absolute number of IMCA referrals was low, thought that healthcare practitioners using the service were benefiting from it. Furthermore, with one exception, all MCA leads thought IMCAs were making a valuable contribution by protecting the interests of adults lacking capacity in healthcare settings. Four of these MCA leads specifically mentioned the benefit of having an advocate who was independent of the decision-making process. One of them did however, point out that all the reports submitted by IMCAs confirmed, rather than challenged, the decisions of healthcare professionals. The one MCA lead who denied that IMCAs protected the interest of adults lacking capacity based his/her views, especially pertinent with respect to serious medical treatment decisions, on advocates' lack of medical knowledge, or understanding of health services. Furthermore, s/he thought that IMCAs could occasionally be quite hostile towards medical practitioners. Only one of the MCA leads we interviewed knew what proportion of IMCA referrals in her hospital were for a change of accommodation, serious medical treatment, or Adult Safeguarding.

When asked to account for the low number of IMCA referrals, our respondents cited the following:

- Most patients lacking decision-making capacity have family or friends able to represent their interests,
- Many treatment decisions are emergency decisions, or if not an emergency, are thought likely to be delayed by the involvement of an IMCA.

Furthermore, the MCA leads we spoke to candidly acknowledged that there were many healthcare practitioners who could not see the value of involving an advocate without medical training in serious medical treatment decisions. The standard solution to this problem was awareness raising events and training opportunities. Eight of the MCA leads said that their hospitals had active training programmes on the legislation and drew staff members' attention to hard and electronic copies of relevant training booklets. One of these MCA leads reported that practitioners often lacked the time to engage with these opportunities and materials. Another respondent acknowledged that what was required was not simply training and awareness rising but a 'culture change' amongst healthcare professionals. At the one hospital, where there was active MCA, training, we were told that all patients entitled to an IMCA were being referred to the service.

Two MCA leads described positive feedback from healthcare practitioners about IMCAs and reported that IMCAs were making a useful contribution to the decision-making process. Two others had received less encouraging feedback: there could be a two-to-three week delay between making a referral and the arrival of an IMCA, and that advocacy in healthcare was an, 'affront' to the professionalism of healthcare practitioners. Another two MCA leads were hearing reports that the IMCAs providing their service were uncommunicative and uncooperative. One of these respondents was hoping for, and waiting for, the IMCA provider organisation to lose their contract from the local authority. This particular MCA lead was more generally concerned about the national picture, improving the quality of IMCA provision and ensuring it was of a consistently high standard across England and Wales. The remaining three MCA leads had received no feedback on their IMCA service although one of them was waiting for a report from the IMCA manager. Nevertheless, these IMCA leads were, in the main, happy with the provider organizations. They justified their view by

alluding to: the speed of responding to referrals and returning phone calls; and willingness to discuss cases. Two of these MCA leads did however, sound a note of caution: one pointing out he had no comparison, and the other by saying there had been no complaints, but equally, no praise.

Considering possible improvements to their service, the MCA leads made two suggestions. The first was that the interval between making a referral and IMCA involvement needed to be reduced, particularly for serious medical treatment decisions. The second suggestion related to ensuring IMCAs understood hospital procedures. This was thought likely to improve communication and speed up decisions. Other suggestions involved procedures for monitoring referrals, especially with respect to BME populations, and reviews of the extent to which the IMCA provision was meeting need.

4. The perspective of local authority MCA leads

The ten local authority MCA leads we interviewed all said they were very happy with the IMCA service they were receiving. They specifically mentioned the professionalism of the advocates and the importance of non-instructed advocacy to the social care sector. Asked to identify the main successes of their respective services, two MCA leads cited how, starting from 'scratch', they were now protecting and supporting a range of clients lacking decision-making capacity. The other MCA leads, also referring to the support and protection advocacy provided, cited:

- The professionalism of IMCAs,
- Their independence from decision-makers,
- The work they had done raising awareness of the MCA; and
- Their close links with the Department of Health.

Asked about possible improvements to the IMCA services, all suggestions pointed to deficiencies on the part of decision-makers with respect to their understanding of the MCA, the assessment of capacity, and the distinction between statutory IMCA cases and Adult Safeguarding. Two local authority leads, aware of criticisms of their provider organisations, attributed these negative judgments to social care practitioners who simply did not understand either the IMCA role or the MCA.

It was generally acknowledged that the number of referrals was lower than it could be, but it was felt that it was increasing. One MCA lead saw a recent decline in referrals as a sign that decision-makers were making fewer inappropriate referrals. Asked specially about the referral rates for the different types of IMCA cases, decisions involving changes of accommodation were the most numerous. One MCA lead reported a particularly high number of Adult Safeguarding cases, reflecting specific local circumstances. Four MCA leads identified encouraging trends in the number of referrals received for serious medical treatment decisions. However, most people reported that there were fewer referrals from the health service than they had anticipated. This was attributed to a lack of awareness of IMCA and the MCA amongst healthcare practitioners. Asked what might be done to remedy this situation, the responses were divided: on the one hand, there were those who advocated more training and information, and closer monitoring of healthcare professionals, and on the other hand, there were those that thought IMCAs themselves needed to have a better understanding of healthcare and begin building

closer relationships with healthcare practitioners. Two local authority leads reported that, as a consequence of the low referral rates, they were expecting their IMCA provider organisations to use their spare capacity, without any increase in funding, to act in cases involving the Deprivation of Liberty Safeguards.

Two MCA leads had very specific messages for the Department of Health. First, that the Department should be doing more to promote the IMCA service in the NHS, and, secondly, that before evaluating the IMCA service, and reaching any conclusions about its performance, it should allow longer for the service to develop. In addition, the third and only other MCA lead who responded to this question expressed concern that the Deprivation of Liberty Safeguards were likely to consume a disproportionate amount of time, and that the relationship between IMCA and generic advocates remained uneasy.

4.1. Black and minority ethnic groups and the IMCA service

Two of the local authority MCA leads we interviewed represented localities with large BME populations and recognized that people from these communities appeared to be having less access to the IMCA service. This was a matter of concern for both of them. For one, the pending renewal of the contract to provide IMCA services offered an opportunity to redraw the contract and include a requirement to promote the IMCA service amongst these groups. This local authority MCA lead was however, unsure as to whether, or not, BME populations were, in fact, under-represented among clients of the service. The other MCA lead was addressing the presumed under-utilization of the service through a local promotion campaign, organised by the local authority. It was additionally noted that competitive tendering, which was believed to favour larger organizations, worked against the interests of BME groups because their interests were better represented by smaller specialist advocacy organisations.

Points for Consideration

The IMCA managers and their staff are doing something exciting: transforming advocacy from what was an ad hoc and a highly variable service into one that is statutory, commissioned on two-to-three year contracts, and working in three significant areas - substitute decision-making in health and social care, Adult Safeguarding, and the Deprivation of Liberty Safeguards. That, after two years, there should be some complaints about the service, misunderstandings as to how it operates, and fewer than the anticipated number of referrals is perhaps only to be expected. It does not necessarily signal any deficiency in the provision or management of the IMCA service.

Assessing the quality of IMCA services was reported to be a problem for Commissioners and MCA leads in health and social care. In part, the problem stems from the novelty of the service, but also from the difficulty of knowing to whom they should turn for an evaluation: the decision-makers who are in effect having their decision scrutinized, or the clients who may be unable to form a view about decisions made on their behalf? Given these problems, it is likely, at least initially, that there will be a considerable reliance on quantitative measures: number of referrals; time taken to respond to a referral; decision-makers formally challenged; average duration of specific types of IMCA cases; number of training events attended by individual advocates etc. Serious consideration needs, however, to be given to a more sophisticated form of evaluation.

The most striking finding to be drawn from our interviews is the difference between how practitioners in social care, compared to those in healthcare, have responded to the introduction of the IMCA service. All of our respondents were aware of, and commented on, this disparity without necessarily understanding why this should be so. However, drawing upon these interviews and previous research, it seems reasonable to conclude that advocacy as conceived and practiced in social care (the model behind the IMCA service and the historic origins of the IMCA provider organisations) does not readily translate to healthcare, especially with respect to serious medical treatment decisions.

Hence, the need for a so-called 'culture change'. Before supporting this call, however, it is necessary to consider how healthcare practitioners make decisions. Our data and experience, tentatively, suggest that healthcare professionals (i) do not readily see a difference between a patient's 'medical interests' and 'best interests'; (ii) question the utility of knowing a patient's wishes and values in a decision-making process where medical expertise is paramount; and (iii) do not see decision-making as an activity in which professional opinions might be scrutinized or challenged by an independent third party without a clinical training. This is in sharp contrast to social care, where advocacy is well established and it is widely accepted that the client's voice, or that of his or her advocate, should play an active role in the decision-making process. The fact that IMCAs have had some success in being involved in change of accommodation decisions in which a patient is being discharged from hospital suggests that these decisions occupy a 'middle' ground between serious medical treatment decisions and change of accommodation decisions in the local authority sector. Progressing the inclusion of IMCAs in serious medical treatment decisions would, our respondents said, require (i) a better understanding of procedures in healthcare; (ii) closer integration of advocates into healthcare teams, and (iii) some basic medical training. Certainly awareness raising and training events appear unlike to deliver a 'cultural change'.

There are also concerns about BME populations. It needs to be established, at a local level, whether men and women from these groups are under-represented in referrals to the service, and if they are, why they may be, and how best to respond.

Appendix Interview Questions

Local authority MCA leads

1. How much contact have you had with your IMCA service? What kind of issues have you discussed?
2. What do you think are the main differences between IMCA services and other advocacy services?
3. Is your LA making use of the IMCA service? (Prompt: how many referrals?).
4. Which referrals do you think are increasing the most?
5. Are there areas in the LA where you think referrals might be higher?
6. What could be done to address this?
7. Do you get feedback/ comments from staff making referrals? What is the general feedback?
8. Are you happy with the organization providing your IMCA services? (Prompt: how are you making that evaluation?).
9. What would you like them to improve on?
10. What do you think is the main success of the IMCA service?
11. Is there anything you would like the Department of Health to know about your experience of the IMCA service?

IMCA Provider Organisations

1. How many local authorities do you provide a service for?
2. How long is your contract with the local authority and is that length of contact reasonable?
3. In the case of joint commissioning what is the extent of the collaboration between commissioners? (Prompt: training IMCAs and staff; awareness campaigning; monitoring for equal value; anything else).
4. How many new IMCA cases are you taking on per month and how far off are you from reaching capacity?
5. How are you balancing demand for statutory IMCA referrals and those made in respect of adult protection proceedings?
6. Are the numbers of referrals from hospitals increasing and is there a noticeable increase in numbers for serious medical treatment decisions? (Prompt: reasons).
7. Are there any particular areas of the IMCA service that referrers are still failing to understand?
8. Are the freely available training materials and guidance sufficient both for your staff and for would-be referrers?
9. Are there any areas where you think your staff could benefit from extra training?
10. Have you experienced difficulties in recruiting suitable staff?
11. From the perspective of your organization, what is going well with the provision of IMCA services?
12. From the perspective of your organization, what aspects of providing an IMCA service have caused the most difficulties?
13. What do you think is your IMCA service's biggest success? (Generally and also give us an example).
14. Is there anything you would like the Department of Health to know about your experience of the IMCA service?

Local Authority Commissioners of IMCA services

1. Do you commission both IMCA services and other advocacy services? If yes: What do you think are the main differences in terms of what you are commissioning?
2. (For joint commissioners only) You have jointly commissioned IMCA services with other local authorities. a) Does this include joint training; joint awareness raising; joint monitoring; anything else? b) What are the benefits of doing it jointly? c) Any problems of doing it jointly?
3. Did you use competitive tendering or did you extend an existing advocacy contract? What were the benefits of the approach you chose? (Do you think competitive tendering is a good way for getting a value for money IMCA service? Why?).
4. How do you monitor the IMCA service? (Does it include monitoring meetings or do you mainly monitor their statistics?).
5. Do you have any ways of looking at the quality of the service?
6. Do you get feedback from the staff making referrals? What issues do they raise?
7. Are you happy with the IMCA service you are receiving? (Prompt: what factors are you taking into consideration when evaluating that service?).
8. What do you think its main strength is?
9. Could the service you are receiving be improved in anyway?
10. Is there anything you would like the Department of Health to know about your experience of the IMCA service?

Hospital-based MCA Leads (if they have them; hospital-based decision-makers if they don't)

1. In your Trust are members of staff making use of the IMCA service? (Prompt: how many referrals?).
2. Do you know how these referrals are divided up between serious medical treatments, changes of accommodation, and Adult Safeguarding? (Prompt: procedures for recording IMCA referrals).
3. IMCA referrals from NHS bodies are lower than expected. Why do you think this is the case?
4. What efforts are being taken in your Trust to address this?
5. Do you get feedback/ comments from staff making referrals? What is the general feedback?
6. Are you happy with the organization providing your IMCA services (Prompt: how are you making that evaluation?).
7. What would you like them to improve on?
8. What do you think is the main success of the IMCA service?
9. Is there anything you would like the Department of Health to know about your experience of the IMCA service?