VoiceAbility

Cambridgeshire Independent Mental Capacity Advocacy (IMCA) Service

Annual Report

1st April 2011 – 31st March 2012

Contents

Forward

This report provides an overview and analysis of service delivery for the fourth year of the Independent Mental Capacity Advocacy (IMCA) service. The report includes comparisons of activity within the year, against previous years, against neighbouring IMCA services, and against the previous year's national findings (The Fourth Year of the Independent Mental Capacity Advocacy Service 20010/11, Dept. of Health). The report also includes qualitative examples of practice, marketing efforts, service developments, outcomes, feedback, and organisational developments.

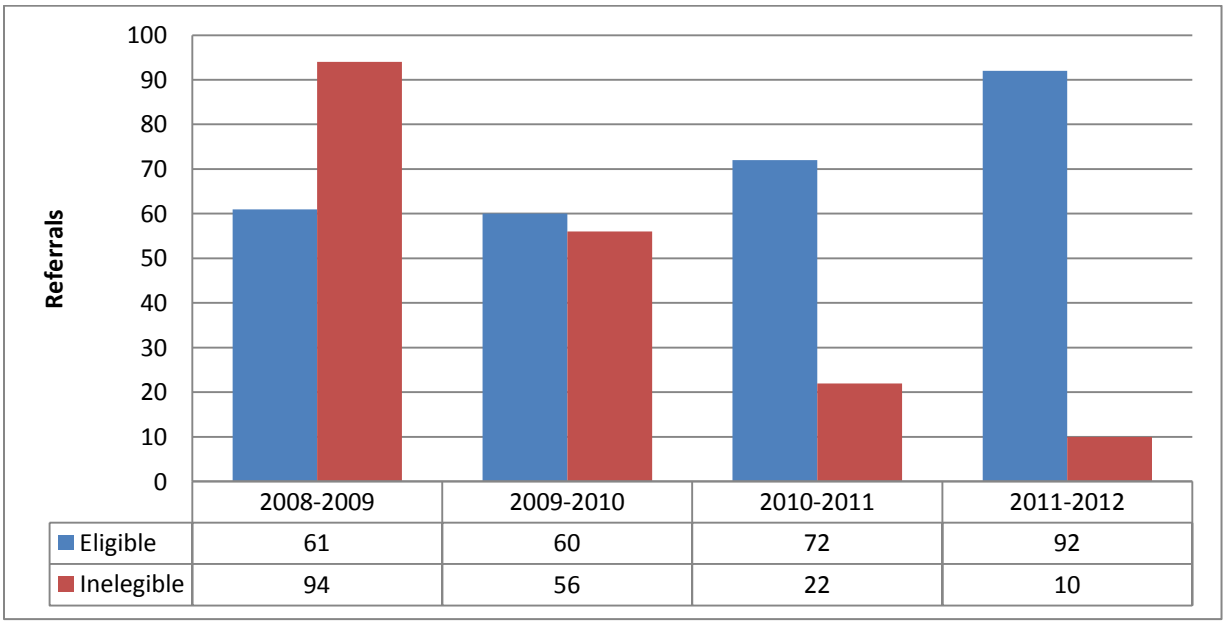
Staffing

The staffing structure has remained consistent from last year, consisting of one full-time and one part-time IMCA. Partway through the year, there has been a change in the part-time IMCA; the new staff member is now qualified to deliver IMCA and Deprivation of Liberty Safeguards (DoLS) work. This structure continues to be successful in meeting the needs of the service, particularly as demand to the service has increased.

Referrals – overview

Graph 1 presents the total referrals received to the IMCA service over the last four years. The graph presents two trends: the year on year increase in the number of eligible referrals, and the year on year decrease in the number of ineligible referrals. The number of eligible referrals has increased by 28%, which followed a 20% increase between 2009/10 and 2010/11. The number of ineligible referrals has reduced by 45%, which followed a 39% reduction between 2009/10 and 2010/11.

Graph 1. Referrals to IMCA Service – 4 year comparison.



	2008-2009	2009-2010	2010-2011	2011-2012
Eligible	61	60	72	92
Inelegible	94	56	22	10

Referrers

Appendix A provides a list of agencies and organisations that referred to the IMCA service. Most of the referrals were made by Cambridgeshire County Council (35%) followed by NHS (24.5%), Cambridgeshire and Peterborough Foundation Trust (CPFT; 20.5%), and Care Homes and a private hospital (7%). Five referrals were received from agencies outside Cambridgeshire: five from Suffolk, one from Hertfordshire, and one from London. If CPFT and NHS are combined to provide a total for health services, it presents a higher number of referrals made from health services than the social care (45% vs. 35%).

The number of referral sources has increased from last year (33) to 45. Addenbrooke's Hospital made the highest number of referrals (13), closely followed by Hinchingbrooke Hospital (12). Although the number of referrals from Addenbrooke's Hospital is similar to that from 2010/2011, the number of referrals from Hinchingbrooke Hospital has increased by eight referrals, most of which were from the Safeguarding Lead.

Huntingdon Learning Disability Team made seven referrals, followed by Discharge Planning (Addenbrooke's) and Fenland Learning Disability Team with four referrals respectively, and March Health and Social Care and St. Neots Planned Care team with 3 referrals respectively.

Social Workers made the most referrals (31), followed by Care Managers (17), Nurses (13), Doctors and Consultations (10), Safeguarding Lead (8), Community Psychiatric Nurses (7), and Occupational Therapists (4).

IMCA service users – all referrals

Table 1 below presents client impairment comparison. The percentage of clients with learning disabilities has remained consistent with previous periods, and is higher than the national average. The percentage of clients with dementia has slightly reduced and is lower than the national average. The percentage of clients of with mental health diagnoses has observed the largest increase, being twice that of the national average. The percentage of clients with acquired brain injury has reduced, being lower than that of the national average.

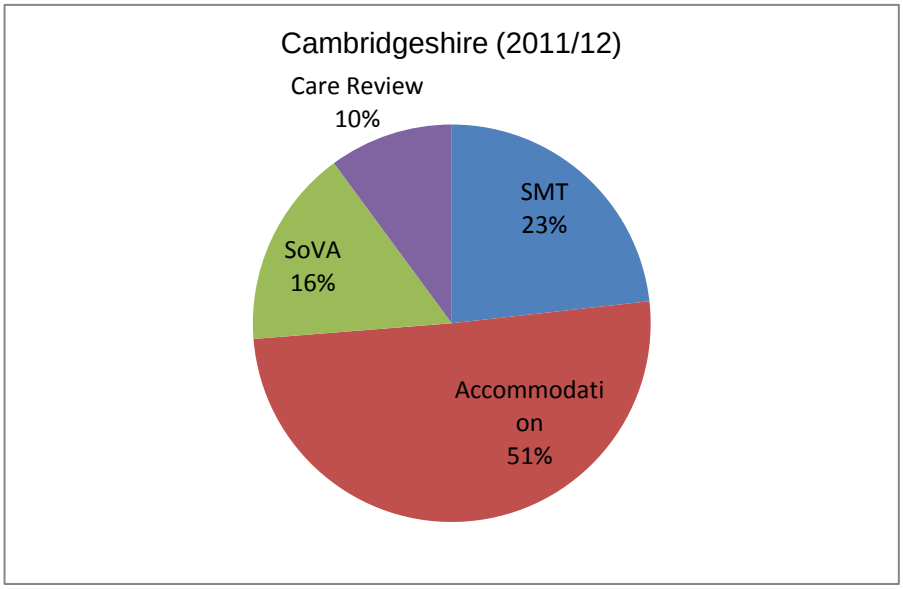
Table 1. Client impairment analysis – 3 year comparison with latest national average

Client Impairment	Percentage 09-10 (%)	Percentage 10-11 (%)	Percentage 11-12 (%)	National Average 10-11 (%)
Learning Disability	24	27.4	**27**	22.6
Dementia	41	33.7	**33**	38.1
Mental Ill Health	17	17.9	**24**	12
No Diagnosis	8	1.1	**2**	4.9
Acquired Brain Injury	8	11.6	**8**	13.2
Physical Disability	>1	8.4	**4**	4
Autistic Spectrum Disorder	>1	0	**2**	1.8

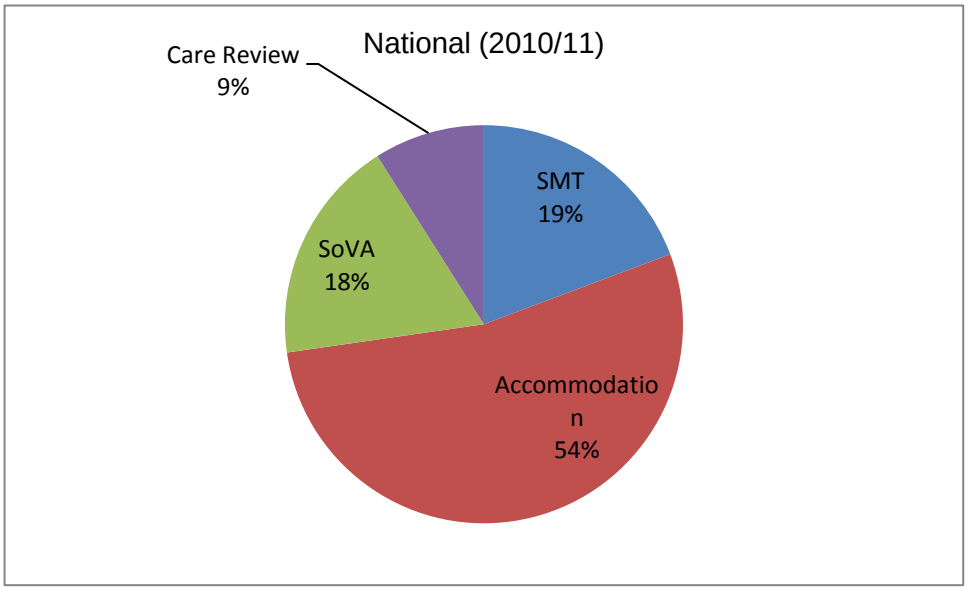
Decisions – all referrals received

Graph 2 presents the eligible referrals received separated by issue type, and Graph 3 presents referrals received nationally. Accommodation accounted for the greatest portion of referrals with 51%, which is lower than the national figure of 54%. The percentage of Serious Medical Treatment (SMT) referrals and Care Reviews was higher than the national figure, however Safeguarding were slightly lower than the national figure (16% vs. 18% nationally).

Graph 2. Eligible Referrals – by issue type

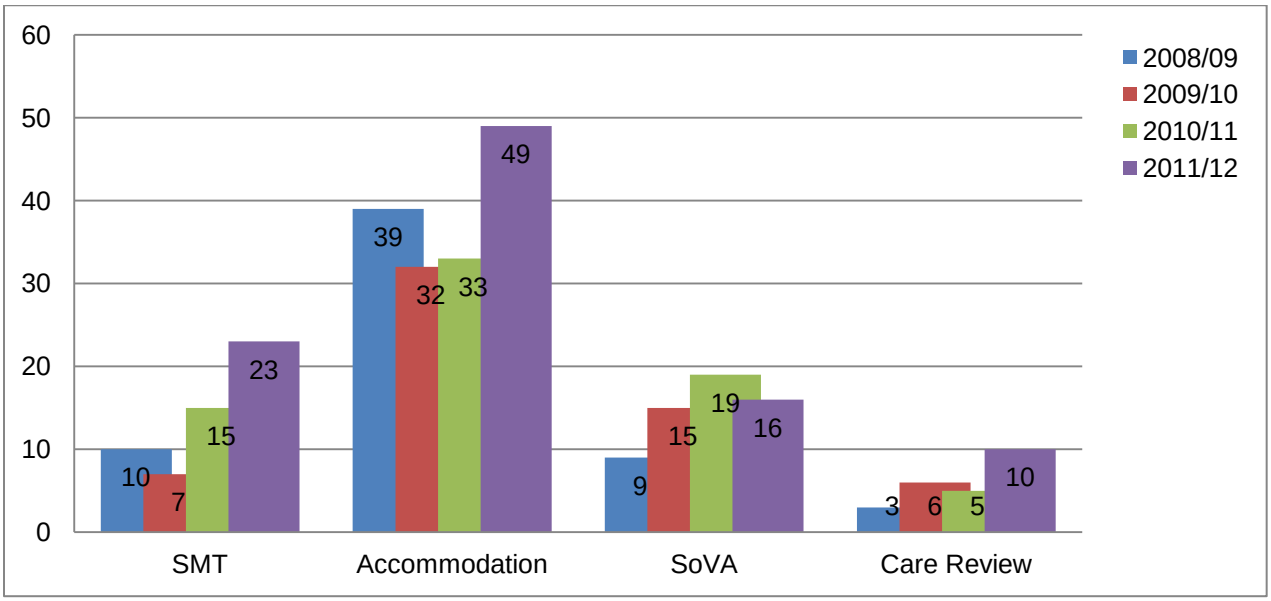


Graph 3. National Eligible Referrals – by issue type.



Graph 4 presents the number of referrals to the service over the previous four years. Most issues have observed a general increase in the number of referrals received, however safeguarding referrals have remained similar to or lower than previous years. Recent awareness efforts are currently targeting safeguarding agencies, and the service will report on progress against safeguarding referrals. Initiatives to raise SMT referrals have been successful as the service has observed a high year on year increase over the previous three years. Initiatives to improve Care Review referrals have observed a modest increase in referrals; this will continue to be monitored.

Graph 4. Eligible Instructions – 3 Year Comparison

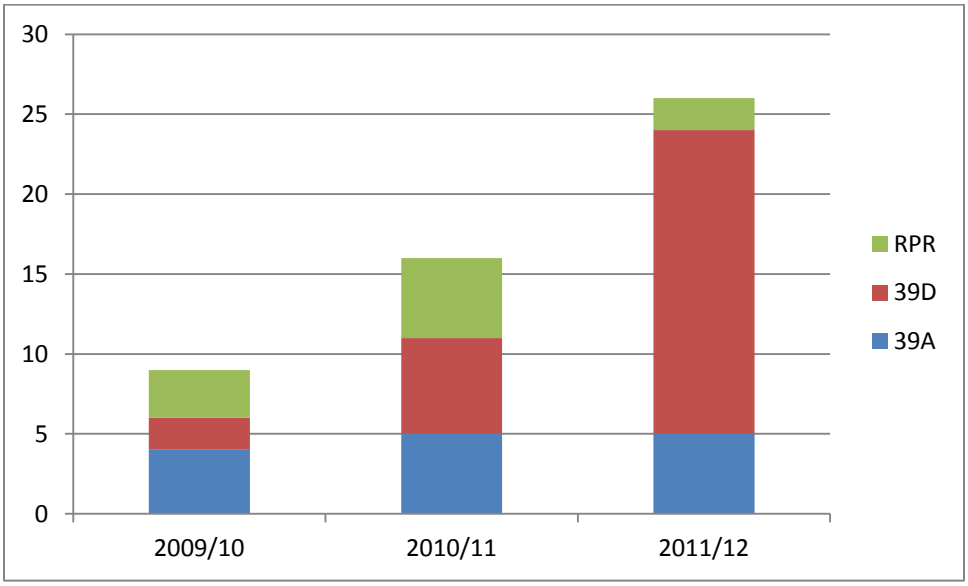


Deprivation of Liberty Safeguards (DoLS) referrals

Graph 5 below presents the DoLS referrals received from 2009, covering 39A, 39D, and Relevant Person's Paid Representative (RPPR) - no 39C referrals were received. Total referrals have consistently increased, which is directly attributed to the high increase in the 39D referrals – 2 referrals in year one, 6 referrals in year two, and 19 referrals in year three. The 'opt-out' model of 39D referrals has been successful to engage with the Relevant Person's Representative as none have decided against having the support from the IMCA.

The number of 39A referrals has remained consistent with 5 referrals received in years two and three, however the number of RPPR referrals has reduced from last year – 5 referrals in year two compared with two referrals in year three.

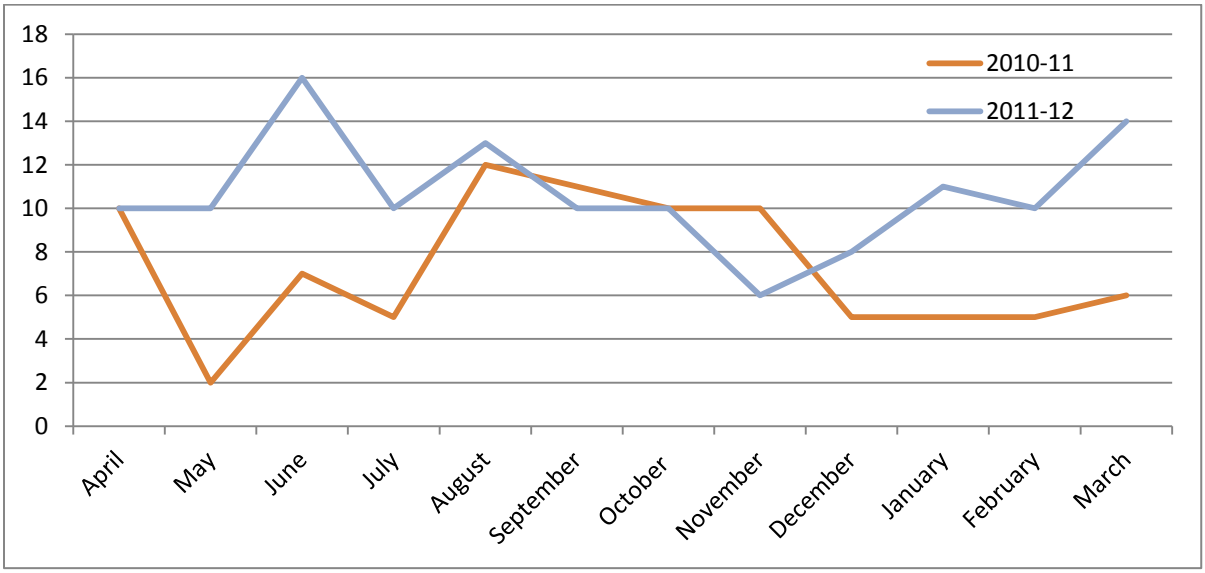
Graph 5. Comparison of DoLS referrals between 2009-10 and 2011-12



Referral trends

Graph 5 below presents the total number of referrals received throughout this year in comparison to last year. There does not appear to be any clear pattern between the two years, nor at different points within the year. There was some reduction in referrals in both years for the period leading up to the festive holiday in December; similar to national referral trends. However, unlike national trends, the service did not observe any significant reductions in referrals during July and August, during seasonal holidays.

Graph 6. Total Referral Trend between 2010-11 (Accommodation, SMT, SoVA, Care Review and DoLS)



Referral Type Regional Comparison

Table 2 presents the referrals received by decision type within the region. The number of referrals received is similar across the three regions, with Suffolk accounting for the highest number of referrals received, followed by Cambridgeshire and Norfolk. The Cambridgeshire IMCA service is however the smallest service within the region (Norfolk have 1.67FTE, Suffolk have 2 FTE).

Although Cambridgeshire received the fewest Accommodation referrals and RPPR referrals, it received substantially more SMT and 39D referrals. Safeguarding referrals are similar to Suffolk, and higher than Norfolk. This presents that Safeguarding referrals in the region are lower than the national average, and has been actioned as an area of priority within each county.

Care Review referrals are similar across the region, and similar to the national level, which has been noted in the Department of Health Report as being too low in comparison to the number of accommodation decisions made. Although in Cambridgeshire various efforts have been made to increase Care Review referrals, it continues to be an issue. Further suggestions have been noted below in the 'marketing' section.

Table 2. Referral Type by Region

	Cambridgeshire	Norfolk	Suffolk
Accommodation	49	61	76
SMT	23	18	10
SoVA	16	8	18
Care Review	10	10	6
DoLS 39A	5	8	7
DoLS 39C	0	0	0
DoLS 39D	19	3	10
RPPR	2	20	7
Total	**124**	**108**	**134**

Long-term Accommodation Referrals

Accommodation continued to account for the highest number of referrals, as well as the highest number of referral sources.

Case study

N, an 82 year old woman, was in hospital after a hip injury sustained in a fall. There were concerns about her ability to look after herself in her own home, which had been found to be in a neglected state, and the risks of further falls and of her wandering. The IMCA ascertained that N was very determined that she should not be placed 'in a home' and that she felt that she could manage at home. Although she had not always previously engaged well with visiting carers, she expressed a degree of willingness to do so if this would mean being able to remain at her own home. She also mentioned, unprompted, to the IMCA that a downstairs room at her house could be adapted for sleeping, indicating an awareness of the risk of falls in relation to using the stairs.

The IMCA's report helped the decision-maker to reconsider her original view that N's well-being would be better served by placement in a residential setting, and to make a decision to give her the opportunity to try to make a success of a return to her own home with a suitable care package. This decision represented a less restrictive option and one that was in keeping with the consistently expressed views of N.

Serious Medical Treatment referrals

Hinchingbrooke Hospital made ten SMT referrals, the highest of this type of referral. Addenbrooke's Hospital made eight referrals, Priory Grange made one referral, and Fenland LDP and Circle support made two referrals combined. The high portion of referrals from Hinchingbrooke is due to the Safeguarding lead's input, as well as the more recently appointed learning disability nurse. The high portion of referrals from

Addenbrooke's is due to the established relationships with key staff and presence at functional groups.

Case Study

S, a 51 year old man, was in hospital having undergone a tracheostomy. He was being fed via a naso-gastric (NG) tube but secretions from a persistent sinus infection were greatly increasing the risk of aspiration and consequent likelihood of aspiration pneumonia. S was exhibiting clear signs of distress and discomfort with the NG feeding (including frequently pulling tubes out). Moreover, the NG tube was not felt to be a viable means of feeding him outside the hospital environment in the longer term.

A decision needed to be made as to whether it was in S's best interests to fit a PEG tube or to attempt to feed him by NG tube whilst in hospital and then orally after discharge. In addition to the risk of aspiration, the non-PEG option was felt to carry a risk of inadequate nutrition which could impede S's overall recovery process and general health prospects.

Although S was unable to communicate, the IMCA was able to ascertain from the staff at his accommodation, that his enjoyment of the taste and texture of certain foods (tea, cake and chocolate) when fed orally, were a key source of pleasure for S and if this were to be lost the impact on his quality of life would be significant. It was felt that his resistance to NG tubes was a probable result of frustration and feelings of hunger, as well as discomfort.

It was confirmed by medical professionals that a PEG tube would enable S to receive optimum nutrition and also to be an effective means of administering medication. It would not prevent him being fed orally at times when other medical factors (e.g. possibility of aspiration) were felt to indicate a low risk, so he would sometimes be able to enjoy his favourite foods. Fitting a PEG tube was also felt to provide the best chance of S being able to return to his accommodation and to continue living in an environment that he was used to and appeared comfortable with. The IMCA highlighted this as the least restrictive option, as well as being in his best interests and the decision was made to carry out the PEG procedure.

SoVA referrals

Huntingdon LDP and Suffolk accounted for the highest number of referrals from a single source, with four referrals received from each. The Suffolk referrals were in relation to safeguarding concerns with a care home during April and May. There were no themes that resulted in the higher number of safeguarding referrals from Huntingdon LDP, which has demonstrated positive engagement with the IMCA service throughout the year.

Other referrers include Cambridgeshire Community Services (2), Discharge Planning (Addenbrooke's; 1), March Health & Social Care (1), South Cambridgeshire East Locality Team (1), and Peterborough Intake and Treatment Team (1). These present fewer referral sources than last year. Meetings with Safeguarding Leads within Social Care have not revealed any identifiable factors for this trend, aside from their concern of over referring. Safeguarding Leads within Health services demonstrated a lack of awareness of both the IMCA service and the MCA. As relationships with key safeguarding leads have now been identified, the service will feedback developments regarding access to the IMCA service from Safeguarding teams and any ongoing awareness raising activities required to increase the referrals received to at least the national average.

Case Study

The IMCA received a referral for a 22 year old woman, who was subject to adult safeguarding procedures, following plans by her family to travel with the client to another country for an arranged marriage with a man chosen by her family to become her husband.

The IMCA discussed the safeguarding process, explored the considered safeguarding measures, and gathered the client's views with the use of picture symbols. The IMCA ascertained that the client was very fearful to marry again and also missed her son from her first arranged marriage.

The IMCA presented her findings verbally and through a report at the strategy meeting. The IMCA advocated for the client's right to a family life, and that the safeguarding measures to prevent her to from being married did not impede her relationship with her son, for example if she was prevented to go to the other country where her son is as a longer-term solution.

It was therefore made part of the decision making process to protect the client against an unwanted marriage, and to make it possible for her to travel safely to see her son. Some interim safeguarding measures were agreed that the client was happy with, whilst the more complex longer-term issue of seeing her son without fear of marriage was escalated to the Court of Protection.

Deprivation of Liberty Safeguards Case Studies

Case Study - 39A IMCA DoLS

R, a man in his early 80s, was in a hospital setting pending a best interest decision being made about his accommodation upon discharge. The IMCA was instructed in respect of the assessment process for a standard authorisation of deprivation of liberty and established that R was not happy with his current situation (and had on one

occasion managed to leave the ward and return to his home address from where he was returned by police). R was focused on the issue of his longer-term accommodation and entertained a wish to live overseas near his sons and daughters.

It was apparent from both R and the ward staff that he responded well to opportunities to go out accompanied (he was physically fit and enjoyed walking). The IMCA advocate for a condition that, in the event of a decision to grant a standard DOLS authorisation, R receives regular opportunities for accompanied walks off the premises, if this is not covered by care–planning.

The IMCA also advocated for, (again, if it could not be encompassed by care planning alone), a condition to promote and maintain R's independence and skill level in relation to daily living activities, such as preparing meals and snacks. This could help optimise R's chances of a successful return to a level of independence more in line with his wishes, all other factors being considered.

Case Study – 39D IMCA DoLS

The IMCA provided represented an 83 year old man (P) who had been admitted to a psychiatric ward whilst suitable alternative accommodation was sought. The IMCA also supported the RPR to understand the DoLS and her rights within this. To prevent replication of effort between the 39D IMCA and the RPR, and to maximize support for P, the IMCA ensured there were regular communication and clarity over who would be doing what to take forward the issues.

There were no conditions attached to the authorisation so the IMCA monitored P in terms of how the deprivation affected his wellbeing, and also ascertained his wishes regarding options for future accommodation.

The client benefitted from regular visits from the IMCA and seemed to enjoy talking about his family and previous jobs and homes he had lived in. The IMCA represented these views in supporting the decision making process to find a suitable alternative placement, and supported RPR in ensuring adequate progress towards this. This enabled an appropriate placement to be identified, which resulted with the client move and the authorization ending.

Case Study – RPPR

A, a 79 year old woman, was the subject of a standard DoLS authorisation, having been placed in a residential care setting after being discharged from hospital. At the time of the accommodation best interest decision, she had been clear in expressing her wish to return to live at her own home but the decision was that this would not be in her best interests. In the role of RPPR, regularly meeting with A, the IMCA was able to raise with the management of the home that A found the level of monitoring to be intrusive, for example, staff frequently asking her if she was OK and also the feeling that she was

being spied on. This resulted in the staff being encouraged to adopt a more “arm’s length” approach.

A’s attitude to being in the home changed as she became more settled (and her physical heath improved), to the point that she expressed satisfaction with her environment and the care she received, and she stated consistently that she would not wish to be anywhere else. The IMCA, in consultation with the Managing Authority, requested that the Supervisory Body carry out a review of the authorisation in advance of the expiry date. This took place and the decision was made that there was no longer a deprivation of liberty within the meaning of the MCA DOLS stipulations.

Feedback from referrers

Table 3. Feedback forms returned from referrers.

Questions asked on the form	Excellent	Good	Not Good Enough	Poor	N/A
How good was the advocate at representing the client?	10	3	-	-	-
How good was the advocate at getting decision-makers to consider the issues in the client’s situation?	11	2	-	-	-
How good was the advocate at ensuring decision-makers took into account all the issues raised relating to the client's situation?	10	3	-	-	-
How good was the advocate at ensuring the client's rights were upheld?	11	2	-	-	-
Overall, how do you rate the service the advocate gave?	11	2	-	-	-
Was the advocate able to ensure the decision-making process was fair in accordance with the requirements of the MCA or SoVA procedures?	11	2	-	-	-
If the advocate had to challenge the decision, how effectively was this done in your opinion?	1	1	-	-	-

Comments

"Excellent facilitations"
"I really appreciate the wonderful works being done by [IMCA]"
"Very Satisfied"
"The IMCA was efficient and thorough and ensured all correct people were contacted"
"I am happy with the quality of advocacy provided"
"Excellent verbal as well as written communication"
"The IMCA report is one of the very best I have come across, all credit to [IMCA]"
"Kept informed"
"Outcome was reached in a timely manner"
"Job well done for those who have no capacity"
"Advocacy service was delivered promptly with the interests of the service user firmly at the forefront of all decisions"
"Advocate was very professional in all his dealings with service user and all professionals"
"Prompt input and kept me up to date with his progress"
"Prompt, helpful and considerate giving a balanced view on behalf of the client"

Complaints about the IMCA service

None.

IMCA Outcomes

There were 85 cases closed this year with the following outcomes achieved:

Outcome Achieved	Percentage of cases (%)	Outcome achieved	Percentage of cases (%)
The person's views, feelings, values and beliefs were ascertained	98%	The person's views, feelings, values and beliefs were made known to the decision maker	98%
The person's rights, including those under the MCA, were made known to a third party	99%	Decision makers took the advocate's findings, written or verbal into account when making a best interest decision	85
The advocate challenged the decision or the process either formally or informally	2%	The person was involved in the decision making process	95%

39D IMCA Outcomes

There were 17 cases closed this year with the following outcomes achieved:

Outcome Achieved	Percentage of cases (%)	Outcome achieved	Percentage of cases (%)
The RPR has a greater understanding of the particular DoLS; what it is, why it has been granted, and what the conditions are.	94	The RPR has been supported to present the information to the RP in ways that are easily accessible.	94
The RPR has a greater awareness of their role and understands the role of the Managing Authority and Supervisory Body.	94	The RP received information and support, both of which increased their involvement in the decision-making process.	94
The RPR is aware of how to trigger a review or challenge in the Court of Protection.	94	The 39D IMCA made the Supervisory Body aware of any disagreement between the RPR and RP.	12

Marketing

Table 4 below presents the awareness raising sessions carried out. The IMCA service has continued to focus marketing activities towards hospitals due to historically variable engagement. The activity has involved both maintaining relationships that were established last year, and developing ways to address any barriers to the service. The latter has included, for example, incorporating the IMCA service as part of the Care Pathway for people with learning disabilities entering Addenbrooke's Hospital, developing tools to support training and induction, and having a named contact to raise any queries about referring.

These efforts have successfully increased engagement for SMT and accommodation decisions (i.e. discharge planning). The service has been focusing awareness raising activities towards safeguarding leads to increase safeguarding referrals. This is being

followed up with regular contact with key staff to monitor the level of engagement and agree any further development work needed.

In addition to seeking Care Review referrals through the decision maker for an accommodation decision, the IMCA will agree, prior the end of their involvement, who will take responsibility to refer for the Care Review. This can include the Managing Authority, identifying a contact in the new team that will carry out the review, or the IMCA.

Geographically, there is positive engagement from Huntingdonshire, East Cambridgeshire and Fenland; however, the number of referrals is low in City and South regions, in respect of the population size. The service will identify key contacts within Adult Social Care to raise this with.

To ensure continued engagement from CPFT, the service has organised with Mental Health Act Managers in July, and is arranging to meet with the Community Mental Health Team for Older People. This will help identify further contacts to develop links with to monitor referral rate and any development actions.

Table 4. Awareness raising sessions.

Addenbrooke's Hospital	• Discharge Planning • Learning Disability Working Group • Vulnerable Adults Working Group • Learning Disability Care Pathway • Training and Induction programmes
Brookfield Hospital	• Lord Byron Ward • Dentistry
North Cambridgeshire Hospital	• North Locality Team
Arthur Rank Hospital	• Staff meeting
Care Review	• Head of Complex Cases
CPFT	• E-Learning modules
Hinchingbrooke Hospital	• Nurses
GP & Health Services	• Information distributed via Service Improvement Facilitator to health services. This was part of initiative to improve access between volunteer and health services. • Nuffield Road GP Surgery
Safeguarding	• Information distributed via Safeguarding Operational Manager • Session on IMCA at Adults Safeguarding Leads training 22nd March

Organisational Developments

VoiceAbility was awarded the the IMCA Specific Review Component of the A4A Quality Performance Mark (commonly referred to as the QPM+). Martin Coyle, Deputy Chief Executive at A4A, said in his report:

"…The IMCA service … is seen to be responsive, flexible, engaging, thorough and person centred. There was remarkably positive feedback from referrers who had used the service and sample of IMCA reports evidenced thorough, detailed and appropriate work by IMCAs. VoiceAbility's IMCA services meet all the requirements of the IMCA Specific Review and excel in some areas. The service appears to live up to its mission to ensure that the service user are kept central to decisions made about their life. As a result I am happy to award VoiceAbility the IMCA Specific Review component of the Quality Performance Mark".

Reiz Evans
Service Manager
Cambridgeshire

Appendix A – Eligible referrals to the service listed by teams

Team	Number of Referrals
Addenbrooke's Hospital	13
Cambridge Physical Disability Team	1
Cambridge South City OP	1
Cambridgeshire Social Services	2
Cambs Community Services	2
Care Home	4
CMHT-OP	2
CPFT	2
David Clarke House	2
Discharge Planning – Addenbrooke's Hospital	4
Discharge Planning Team – Hinchingbrooke Hospital	1
Discharge Planning – Fulbourn Hospital	2
East Cambs & Fenland Continuing Healthcare Team	1
East Cambs CMHT-OP	1
East Cambs LDP	2
Ely CMHT-OP	1
Fenland Assertive Outreach Team	1
Fenland CMHT	1
Fenland CMHT-OP	1
Fenland LDP	4
Fulbourn Hospital	2
Hertfordshire Social Services	1
Hinchingbrooke Hospital	12
Huntingdon LDP	7
Huntingdon Physical Disability Team	1
Huntingdon Recovery & Rehab	1
ILN East	1
London - Ealing	1
March Health and Social Care Team	3
North City Team	1
North Intake & Treatment Team	1
Older Persons Mental Health Services	1
Peterborough Intake & Treatment	1
Physical Disability Team	2
Priory Grange	2

Team (continued)	Number of Referrals
Rehab & Recovery	1
Ringshill Care Home	1
S. Cambs East Locality Team	1
South Cambs East OP Team	1
South Cambs LDP	1
South Cambs Rehab & Recovery Team	1
St Ives & Ramsey Planned Care Team	1
St Neots Planned Care Team	3
Suffolk	5
Wisbech Health and Social Care Team	2