Evaluation of the Adults With Incapacity (Scotland) Act 2000
Part 4
Evaluation of the Adults with Incapacity Act (Scotland) 2000 Part 4

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Scottish Government Social Research
2009
The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.
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# Glossary of Terms

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<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>DWP Appointeeship</strong></td>
<td>The Department for Work and Pensions can appoint someone else to receive a person's benefit and use the money to pay expenses such as household bills, food and personal items. This can be arranged through a system known as an appointeeship. An appointee does not have the authority to deal with capital or other income belonging to the person. Appointees can only deal with the income from benefits, except in the case of small amounts of savings which can be used to meet unforeseen emergencies.</td>
</tr>
<tr>
<td><strong>Guardianship Order</strong></td>
<td>A court appointed order under the Adults with Incapacity (Scotland) Act 2000 appointing a person to manage the financial and/or welfare affairs of a person deemed unable to manage such matters. A guardian may make ongoing decisions and orders generally last three years.</td>
</tr>
<tr>
<td><strong>Section 94 of the Mental Health (Scotland) Act 1984.</strong></td>
<td>Section 94 allowed administrators of hospitals to manage the funds of patients who are liable to be detained under the Mental Health (Scotland) Act 1984, or who are receiving treatment for mental disorder. There is no equivalent legislation to authorise the managers of other care establishments to manage the finances and property of incapable residents.</td>
</tr>
<tr>
<td><strong>Power of Attorney (POA)</strong></td>
<td>Gives authority to a named person to make decisions or actions on behalf of an individual when the person is unable to make decisions relating to their health, welfare, money or property. The individual decides, while they are still capable of understanding what they are doing, who will act as their attorney and how incapacity is to be determined in relation to decisions about the matters to which the power relates.</td>
</tr>
<tr>
<td><strong>Authorised Establishment</strong></td>
<td>An establishment authorised and registered by a Supervisory Body. These may include NHS Hospitals; The State Hospital; Independent Hospitals; private Psychiatric Hospitals; Care Home Services and Limited Registration Services.</td>
</tr>
<tr>
<td>Supervisory Body</td>
<td>Have responsibilities for authorising and supervising establishments. NHS Boards, State Hospital Board and The Care Commission are Supervisory Bodies under Part 4 of the Act</td>
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ACKNOWLEDGEMENTS

The authors would like to thank all those who took the time to complete the postal questionnaires sent out to them and all those who agreed to be interviewed as part of this study. Thanks are also due to the Paul McPeake for his help in facilitating the study and in sending out the questionnaires, in helping to organize the interviews and in formatting the report. We are also grateful for the support and advice we received from Christine Sheehy, Jan Raitt and Fiona Hodgkiss from the Scottish Government. The authors would also like to thank the members of the Research Advisory Group; Joe McGhee, NHS Forth Valley; John Dearden, Mental Health Partnership, NHS Greater Glasgow and Clyde; Ian Cairns, Mental Welfare Commission; Susan Donnelly, Care Commission and Sandra McDonald, Office of the Public Guardian for all their help and advice in carrying out this study.
EXECUTIVE SUMMARY

Introduction

The Adults with Incapacity (Scotland) Act 2000 (AWI) sets out the system for protecting the welfare of adults in Scotland who are unable to take decisions for themselves. Its aim is to help adults (aged 16 plus) who lack the capacity to make decisions on some or all aspects of their lives. It enables health care professionals, carers or others to have legal powers to make financial, welfare and health care decisions on their behalf. Part 4 of the Act deals with the management of financial affairs of adults with incapacity who live in what are termed authorised establishments, the majority of which are care homes. It enables managers of such authorised establishments to manage the finances of resident adults who are incapable of managing them themselves. Authorised establishments are overseen by one of three supervisory bodies: Health Boards; The State Hospital and the Care Commission.

This research was commissioned by the Scottish Government Health Analytical Services Division on behalf of the Primary and Community Care Directorate, Community Care Division.

The aims of the study were to:

- Assess the effectiveness of Part 4 of the Act including: the uptake; benefits to residents; and key stakeholders’ experiences of using the provisions in Part 4 of the Act,
- make recommendations on any action needed.

Methods

The project used both quantitative and qualitative research methods, involving questionnaires, face-to-face and telephone interviews. There were three main stages to the research:

- A survey of supervisory bodies
- Case studies involving care homes in 4 contrasting health board areas
- Interviews with groups representing the interests/views of those whose finances might be managed under AWI Part 4.

Questionnaires were sent to all 14 territorial Health boards, the State Hospital and the Care Commission, who act as Supervisory Bodies. The questionnaire was designed to collect data on a number of issues around AWI Part 4 including the number of people currently having their finances managed under AWI Part 4, the policies and procedures associated with Part 4 and monitoring of Part 4.

The questionnaire survey was followed up with interviews with 13 Health Board representatives.

The second stage, the case studies, involved interviewing 11 care home managers from care homes serving a range of clients spanning the private and charitable sectors.
The third stage involved interviewing 9 representatives of organisations of and for disabled people and older people including representatives from for example, Alzheimer’s Scotland, Capability, Enable, the Highland user’s Group, the Mental Welfare Commission and the Office of the Public Guardian.

All interviewees were asked about their experiences and views of AWI Part 4.

**Limitations of research**

Difficulties were encountered in conducting this research principally due to the low level of use of AWI Part 4 by authorised establishments and the difficulty in identifying care homes that were currently managing the finances of any of their residents under AWI Part 4. Nevertheless the research did reveal a number of themes around the use of the legislation.

**Findings**

Overall, we found that there was a very low level of uptake of AWI Part 4 across all sectors. Other broad themes to emerge from the study included:

- People welcomed the underlying principles of the AWI. Interviewees felt that it not only protected both them and their residents or patients but that it also afforded them the opportunity to take action to improve residents’ quality of life.

- The legislation itself was described variously as ‘ambiguous’, ‘difficult to interpret’, and ‘complicated to apply for’. Almost all informants commented on how difficult it was to apply for a certificate of authority to manage an individual’s funds.

- Whilst knowledge about Part 4 of the Act was fairly well disseminated throughout the service providers, interviews carried out as part of this research with organisations of and for people who may benefit from Part 4 suggested that it was not widely known amongst the general public.

- The vast majority of people living in care homes and hospitals who were not capable of managing their own finances were having their funds managed through a DWP Appointeeship.

- The use of AWI Part 4 to manage savings accrued through benefits was raised as an issue throughout the health and social care sectors. It was reported that differing interpretations of how funds should be managed could result in difficulties in the transfer of patients from hospital to care homes.

The report also identifies a range of factors which may affect take up of AWI Part 4, these included:

- Difficulties in setting up a bank account. People complained about the number of forms they had to complete to set them up and the amount of
supporting evidence the banks required, such as letters from a GP or other medical professional.

- There were also complaints about poor knowledge of the AWI in the banks themselves, many of which operated within an English legal framework and had no understanding of the legislation.
- Lack of support in working with the Act. This was felt by both those who worked in the supervisory bodies and those who worked in the authorised establishments. Under the Act people felt they were being forced to make decisions about and take action on, financial matters that they were not themselves qualified to make.
- Many of those working for the supervisory bodies interviewed as part of this research were unsure about their suitability for this role. They felt that they were working outside of their area of expertise and were being granted too much autonomy, were not sufficiently regulated and were uncomfortable in their roles.
- There were concerns around the length of time it took to process an application to manage funds under AWI Part 4.
- In planning to meet the needs of adults with incapacity, hospitals and care homes had established review meetings for individuals. These provided the opportunity for the individual, family, friends, social work, nursing and care staff to discuss ways in which funds could best be spent to improve the quality of life of the individual. These meetings were not just restricted to people with funds managed under AWI Part 4.

The following sections present the study findings for each of the three sectors in which AWI Part 4 operates.

**Health boards**

Eleven of the 14 health boards responded to the questionnaire although three of these failed to provide full information.

**Uptake and use of AWI Part 4**

- From those health boards who did participate in the research it was clear that uptake of AWI Part 4 was much lower than anticipated and that there was variation between health boards.
- The changing provision of care throughout the 1990s has meant that hospitals are no longer providing long term care arrangements for large numbers of individuals. Therefore the numbers of people potentially eligible to have their finances managed under AWI Part 4 may be lower than anticipated.
- Differences in the social and physical environment in which the various health boards operate may result in individuals having differing access to wider family and community ties, enabling them to use mechanisms, other than AWI Part 4, to manage finances. This was of particular relevance to the more remote/rural areas where it was reported that strong social and familial ties provided alternatives to using AWI Part 4.
- A number of health boards saw monies accrued from DWP benefits as falling within the remit of DWP Appointeeship; others viewed the accrual of such
funds as requiring the use of AWI Part 4. This was reported to have the potential to create difficulties for transfers between Health boards.

Knowledge and views of AWI Part 4

- Health board respondents felt AWI had clarified the position for many health boards with regard to handling the finances of their patients who had incapacity. Interviewees recognised the potential of the Act to enable their hospitals to act for individuals and improve their quality of life.
- The legislation, it was felt, was designed to be used only when all other possible alternatives were exhausted.
- Concern was expressed around the letter of the law with some respondents reporting that they found it to be difficult to interpret. AWI Part 4 was seen as complex and ambiguous in places.
- Part 4 of the Act was felt to be of little value to short stay patients because of the length of time required to apply for a Certificate of Authority.

Health Board as Supervisory Body

- Some health boards expressed concern about their suitability to act as a supervisory body and were uncomfortable in that role.
- The majority of health boards had developed policies, procedures and monitoring mechanisms in relation to AWI Part 4. Patient Fund Systems were utilised to manage patients’ funds and a range of auditing tools were used to ensure the appropriate use of funds.

Managing Funds

- Decisions around the spending of monies involved the multi-disciplinary review team which included the patient, family, social worker, consultant, staff nurse and key care workers as well as patient fund officer.

The State Hospital

Information on the use of AWI Part 4 was provided by one informant.

- The State Hospital viewed Part 4 as an important and necessary piece of legislation.
- It was nonetheless viewed as overly complex and bureaucratic.
- At the time of interview, five patients’ finances were being managed under AWI Part 4. Opportunities to spend funds on patients were limited due to restricted access to activities available to patients.
- Training on AWI Part 4 had been made available to staff at all levels.
The Community Setting

Uptake and use of AWI Part 4

- Data provided by the Care Commission suggested that thirty care homes across Scotland were recorded as having residents whose funds were managed under AWI Part 4. This low level of uptake meant that few (3) of the eleven care home managers interviewed had any direct experience of using Part 4.

Knowledge and views of AWI Part 4

- Care home managers were aware of and had some knowledge of the principles of AWI in general and the intentions of Part 4.
- Care home managers felt that the policies and procedures around AWI Part 4 were too complex and too demanding, both in terms of time and resources. Concern was expressed by care home managers about their ability to claim for the time spent managing patients’ finances from patients’ funds.
- Care home managers recognised the importance of the AWI Part 4 in supporting the rights of clients to access monies. They also recognised the support and protection offered to themselves and their clients in the management of funds.
- Managers voiced the need for more ‘user friendly’ information, support and training on AWI Part 4.

Care Commission as Supervisory Body

- Care home managers reported that their experience of the Care Commission as a source of support and information around AWI Part 4 was dependent upon the knowledge and expertise of their local Care Commission officer.

Managing Funds

- Banks were deemed to have varying levels of awareness of the legislation and as a result care home managers experienced difficulties in establishing and managing bank accounts for residents.
- The level of responsibility expected of care home managers by AWI Part 4 was of great concern to managers, who felt that they did not have the expertise to manage the finances of clients.
- Those managers whose homes were part of a larger organisation had clear policies and procedures in place to manage AWI Part 4.

Recommendations

In light of the findings set out in this report, this concluding section outlines a series of recommendations from the study.

- The management of accrued benefits. The DWP and Scottish Government need to consider the need for clearer advice on how monies accrued from DWP benefits should be handled. The current position is not sustainable and
a lead should be given to direct the supervisory bodies. It is our recommendation that a limit should be set of say £1000 and when that figure is reached, regardless of the origin of that money, its management should come under the control of AWI Part 4.

• **The application procedure should be re-examined** The application procedure is, as it stands, far too complex and time consuming. Whilst under the current demands of the legislation this process is necessary to meet the requirements of the Act, the possibility of changing the legislation to simplify the procedure should be examined. The introduction of a fast track procedure should also be explored so that, in an emergency, action can be taken. This would be particularly helpful for people with a mental health problem, as they are often subject to temporary incapacity during which time they may accrue considerable debts.

• **A light touch element should be introduced.** Currently many managers are put off AWI Part 4 because of its bureaucracy and ‘one size fits all approach’. Every penny spent under AwI Part 4 has to be accounted for. Some form of risk assessment needs to be included. The possibility of allowing a weekly spend of say £30 without too much paperwork should be examined. A sliding scale could then be adopted, with spends of say between £30 and £100 requiring a greater level of accountability and any spend over £100 should be completely transparent.

• **New guidance should be provided on what money can be spent on.** This guidance should make it clear that managers of care homes can claim back some costs associated with implementing the legislation and with managing a client’s finances. Information about other services that AWI Part 4 monies can be used for, such as befriending schemes, should also be made clear.

• **The suitability of Health Boards and the Care Commission to act as supervisory bodies should be examined.** Representatives from both of these organisations have expressed concern about their roles under the legislation. Neither of these organisations have much experience of the sort of financial auditing required under the legislation. There is also the potential for conflict of interest, especially with health boards. An external body such as the Office of the Public Guardian may be better suited to this role.

• **The provision of more publicity and better information on AWI Part 4.** There is clearly a need for better publicity in this area, both in the care sector and beyond. Banks should be a main target of any publicity campaign. Given the high degree of staff turnover in these services there will be an ongoing need for continual information in this area.

• **Remind Supervisory Bodies of their roles in terms of record keeping.** The Health boards and the Care Commission have a clear duty to keep and maintain up-to-date records of the certificates they have issued. A simple annual return to be completed and submitted to the Department of Health and Community would ensure that such data were routinely collected and recorded and would enable more effective monitoring.
1 INTRODUCTION

1.1 This chapter presents a brief overview of Adults with Incapacity (Scotland) Act Part 4 (AWI Part 4) and gives a background to the research. It starts with an outline description of the AWI in general and then moves on to discuss Part 4 in particular. It also presents a brief description of previous research on the AWI and on the legislation that preceded the Act. In so doing it sets out the context for the research.

Background

1.2 The Adults with Incapacity (Scotland) Act 2000 (AWI) sets out the system in Scotland for protecting the welfare of adults who are unable to take decisions for themselves. Its aim is to help adults (aged 16 plus) who lack the capacity to make decisions on some or all aspects of their lives. It enables health care professionals, carers or others to have legal powers to make financial, welfare and health care decisions on their behalf.

1.3 Under the general principles of the AWI all decisions made on behalf of an adult with incapacity must:

- Benefit the adult
- Adopt the least restrictive option
- Take account of the adult's present and past wishes and feelings if these can be ascertained
- Take account of the nearest relatives, primary carer or relevant others
- Restrict the adult's freedom as little as possible.

1.4 The AWI also demands that where possible, reasonable and practicable, adults with incapacity are encouraged to use their existing skills or to develop new skills concerning their property, affairs or personal welfare.

1.5 The AWI has the potential to impact on the lives of many people and when originally considered it was estimated that up to 100,000 people might be helped by it (Scottish Executive 1999).

1.6 The evaluation of Part 4 of the AWI was commissioned by the Scottish Government Health Analytical Services Division on behalf of the Primary and Community Care Directorate, Community Care Division. Part 4 of the AWI deals with the management of financial affairs of adults with incapacity who live in, what are termed, authorised establishments the majority of which are care homes. It enables managers of such authorised establishments to manage the finances of resident adults who are incapable of managing them themselves. This research aimed to evaluate the effectiveness of Part 4 of AWI, explore its implementation and operation and indicate where improvements may be made.
1.7 The evaluation of Part 4 was delayed due to transitional arrangements being in place until the end of October 2006 and is the final part of the Act to be evaluated. Parts 2, 3 and 6 of the Act were reported on in 2004 (Killen et al 2004) and a review of the implementation and early operation of Part 5 of the Act was conducted by the Centre for Research on Families and Relationships and Stirling University Department of Nursing and Midwifery in 2004 (Davidson et al).

The Adults with incapacity (Scotland) Act (AWI)

1.8 The origins of the AWI lie in a 1991 publication by the Scottish Law Commission Mentally Disabled Adults – Legal Arrangements for Managing their Welfare and Finances (Discussion Paper No 94). This document examined the laws in Scotland which governed decisions about the finances and welfare of mentally incapable adults and concluded that the current legislation was fragmented, archaic and did not serve to protect adults with incapacity. The Scottish Law Commission (SLC) report also included a draft Bill. The document and its Bill were founded on the principles of autonomy and equity and it aimed to ensure that adults who were incapable of making decisions for themselves were not disadvantaged.

1.9 In 1995 the SLC published The Report on Incapable Adults (Report 151) (SLC 1995), which contained 152 recommendations to establish a comprehensive legislative framework. In 1997, the then Scottish Office, published Managing the Finances and Welfare of Incapable Adults, which adopted most of the SLC’s recommendations. These reports, together with subsequent consultations formed the basis of the Adults with Incapacity Act which was one of the first pieces of legislation passed by the newly established Scottish Parliament in 2000. This Act aimed to introduce a comprehensive hierarchy of provisions for meeting the needs of adults with incapacity whilst allowing for individual interventions.

1.10 Under the terms of the Act an adult is considered to be covered by the Act if they are incapable of—

(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions.

1.11 The Act recognises that incapacity is not ‘an all or nothing’; capacity can vary both temporarily and situationally. Some impairments may result in a temporary loss in capacity and while adults may be deemed incapable of making decisions about one aspect of their life, they are not necessarily
incapable of making decisions about other aspects. An assessment of incapacity is decision specific.

1.12 The Act itself is divided into 7 parts. The Explanatory Notes to the Adults with Incapacity (Scotland) Act 2000\(^1\) describes the 7 parts in the following way:

- Part 1 gives a definition of incapacity and sets out general principles that are to apply to any intervention in the affairs of an adult under the legislation. It defines the role of the authorities that will act under the legislation: the sheriff, the Mental Welfare Commission and local authorities. It creates the new Office of Public Guardian within the Court Service. It also provides for codes of practice containing further guidance to those acting under the legislation.

- Part 2 clarifies the position of attorneys with financial and welfare powers who act when the granter of the power loses capacity. It provides for registration, monitoring and supervision of such attorneys.

- Part 3 sets up a new statutory scheme providing access to funds held on behalf of an adult with incapacity with appropriate safeguards.

- Part 4 provides for hospital and care home managers to manage the finances of patients or residents with incapacity, subject to appropriate safeguards.

- Part 5 confers a statutory authority on medical practitioners and those acting under their instructions to give treatment to adults with incapacity and undertake research in certain circumstances.

- Part 6 creates a new system of welfare and financial intervention orders and guardianship.

- Part 7 includes various other miscellaneous provisions.

1.13 Responsibility for the Act is split between two departments. The Scottish Government Department of Law, Order and Public Safety has overall responsibility for the implementation of the Act and specific responsibility for Parts 1, 2, 3, 6 and 7 and the Scottish Government Department of Health and Community Care has overall responsibility for Parts 4 and 5.

1.14 This report focuses on Part 4, although other parts are referred to as appropriate. Part 4 replaced Section 94 of the Mental Health (Scotland) Act 1984 which authorised the management of the finances of incapax patients by hospital managers. Under the 1984 Act all that was required for the hospital to take over management of a patient’s funds was for a responsible medical officer to state that, in his opinion, the patient was incapable of managing and administering their own property and affairs, by reason of their mental disorder. However, if the patient had funds of more than £5,000 the consent of the Mental Welfare Commission was required before the hospital managers could take up these powers.

\(^1\) http://www.opsi.gov.uk/legislation/scotland/acts2000/en/aspen_20000004_en_1
1.15 This section provides a brief description of the AWI Part 4. AWI Part 4 deals with the management of financial affairs of adults with incapacity who are residents in a care home, hospital or similar setting by the manager of that home.

1.16 These places of residence are defined as ‘authorised establishments’ by the Act. There are three supervisory bodies for the purposes of Part 4 of the Act and they have responsibilities for authorising and supervising the establishments as listed below:

<table>
<thead>
<tr>
<th>Supervisory Bodies:</th>
<th>NHS Boards</th>
<th>State Hospital Board</th>
<th>Care Commission</th>
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<tr>
<td></td>
<td>NHS Hospitals</td>
<td>State Hospital</td>
<td>Independent Hospitals</td>
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<td></td>
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<td></td>
<td>Private Psychiatric Hospitals</td>
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<td></td>
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<td></td>
<td>Care Home Services</td>
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<td></td>
<td></td>
<td></td>
<td>Limited Registration Services</td>
</tr>
</tbody>
</table>

1.17 The roles of the supervisory bodies are to:

- In the case of the State Hospital board and Health boards, grant notes of authority to managers in the state hospital and NHS hospitals to manage funds under Part 4. For those establishments required to register with the Care Commission their registration designates them as authorised to manage finances under Part 4.
- Grant certificates of authority to managers in authorised establishments to manage a resident’s finances.
- Monitor the management of resident’s funds;
- Investigate complaints.
- Revoke authority to manage funds

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• Take over management of resident’s finances on short term basis if appropriate\(^3\).

1.18 For NHS Scotland hospitals and the State Hospital the appropriate NHS Board or state hospital issues a formal Note of Authority which conveys the authority for managers to manage under Part 4 of the Act. For those establishments required to register with the Care Commission, their registration under the Regulation of Care (Scotland) Act 2001 designates them as authorised. Registered establishments do however have the right to opt out of managing their resident’s finances.

1.19 Managers who are authorised under the Act may manage cash or accounts or movable property on behalf of residents with incapacity. These funds must be used to the benefit of the residents. A manager must, before the Act is used, consider alternative approaches and determine if AWI Part 4 is the most appropriate. Their actions must support the autonomy of the individual as far as possible. Before they can take any action under AWI Part 4 the view of a medical practitioner must be sought to determine the resident’s capacity to manage their finances. This must be reviewed regularly and expires after 3 years.

1.20 In a review of section 94 of the Mental Health (Scotland) Act 1984, the previous legislation which dealt with the finances of incapable adults in Scotland, concerns were raised about the reluctance of staff to use residents’ finances. It was felt by those who controlled the finances that to spend money on certain patients would be to waste it. As a result no effort was made to ensure that all income available to the patient was claimed, and money received or held money was preserved rather than being used to enhance the quality of life (Scottish Home and Health Department 1985). There was also some concern expressed about the use of residents’ finances to fund services already provided by the NHS. AWI Part 4 was drafted to address these issues.

1.21 Under the terms of the Act a manager may:

• claim, receive, hold and spend any pension, benefit or allowance or other payment to which the resident is entitled - other than Department of Work and Pension (DWP) benefits and contributions which are managed under DWP Appointee-ship arrangements;

• claim, receive, hold and spend any money to which the resident is entitled;

• hold any other moveable property (e.g. personal effects and possessions) to which the resident is entitled; and

• dispose of (e.g. by sale) the resident’s moveable property.

\(^3\) “Code of Practice for Supervisory Bodies” sets out in detail the principles, rules and guidelines which they should follow to meet their obligations under the Act.
Managers may only spend a resident’s money on items or services which are of benefit to the resident and they may not spend money on items or services which are provided by the establishment to or for the resident as part of its normal service. Examples of ways of benefiting residents who lack capacity from their own resources and funds can include:

- purchasing beneficial therapies such as hair dressing and aromatherapy;
- engaging a mobility assistant or supporter for a few hours a week to undertake befriending activities;
- meeting mobility requirements over and above those provided for by the care home or hospital e.g. electric wheelchair;
- purchasing holidays or week-end breaks;
- paying for outings.

To further safeguard the interests of the resident, managers must first obtain the explicit consent of the relevant supervisory body to manage any matter where:

- In the case of cash or funds, it has a value greater than £10,000; or
- In the case of disposals of moveable property, the amount realised would be more than £100.

Managers may not charge residents directly for the management of their financial affairs under Part 4 of the Act, but the costs of operating Part 4 of the Act can be taken into account by establishments in setting any contract prices. DWP benefits cannot be managed under Part 4. Supervisory bodies are not authorised to levy specific fees for the administration of Part 4 of the Act, rather they are expected to recoup costs through normal channels (for example, through registration fees).

Summary

Part 4 of the AWI deals with the management of the financial affairs of adults with incapacity who live in residential establishments, mainly care homes. It came into operation in October 2003. This evaluation of Part 4 will complete the evaluation of the implementation of AWI as promised by Ministers.

The aims and objectives of the research are outlined in the next section.
2 AIMS AND OBJECTIVES

2.1 The aims and objectives as laid out in the original invitation to tender were as follows:

Aim

2.2 The main aims of the research were to assess the effectiveness of Part 4 of the Act including: the uptake; benefits to residents; and key stakeholders’ experiences of using the provisions in Part 4 of the Act, and to make recommendations on any action needed.

Objectives

2.3 The specific objectives of the research were to:

- Determine the uptake of Part 4 of the Act, to include data on:
  - The number of establishments which have applied for authorisation to manage residents finances under Part 4 of the Act.
  - The number of certificates of authority applied for/issued for residents

- Provide some insight into the number of incapacitated adults with income other than benefits who have no-one managing their funds and who are not already benefiting from Part 4 of the Act.

- Explore levels of awareness about the provisions of Part 4 of the Act among managers of establishments, social workers and other key stakeholders.

- Examine the experience of supervisory bodies, managers of establishments and other stakeholders in operating Part 4 of the Act, including factors that may facilitate or hinder the operation of Part 4 of the Act.

- Examine why some managers of establishments have not taken up powers under Part 4 of the Act.

- Assess the extent to which Part 4 of the Act contributes to the improvement of the quality of life for residents.

- Make recommendations on how the provisions of the Act can be improved.

2.4 The next section outlines the methods employed to meet these aims and objectives.
3 RESEARCH DESIGN AND METHODOLOGY

Introduction

3.1 To meet the aims and objectives outlined previously a range of research methods were employed to ensure that both a breadth and depth of information was collected. We adopted both quantitative and qualitative approaches and used self completion questionnaires, and face to face and telephone interviews. As the research progressed some changes were made to the original research design to take account of the emerging findings.

3.2 The research was carried out between November 2008 and February 2009 and comprised of three main stages:

- A survey of supervisory bodies
- Case studies involving care homes in 4 contrasting health board areas.
- Interviews with groups representing the interests/views of those whose finances might be managed under Part 4.

Survey of supervisory bodies

3.3 The first stage of the study was a quantitative survey of all the supervisory bodies in Scotland. Questionnaires were sent to the Chief Executive of all the territorial Scottish health boards, the State Hospital and to the relevant officer in the Care Commission. The questionnaire was designed to determine the number of people currently having their finances managed under Part 4, the number of establishments which had applied for authorisation to manage residents’ finances, the number of certificates of authority applied for, the number of certificates issued and the number rejected and the grounds on which they were rejected. The questionnaire also sought information on other aspects of Part 4 for example the complaints procedure, monitoring and audit procedures and procedures when patients are transferred.

3.4 In addition to gathering the information outlined above, the questionnaire to the health boards and State hospital also asked for details of people to contact in order to clarify responses in the returned questionnaire and to interview for the second part of the study.

3.5 The questionnaire and interview schedule were submitted to the Research Advisory Group for comment prior to being used. A copy of the questionnaires and interview schedule can be found in Appendix 1 and 2 respectively.

3.6 We intended to validate the quantitative data by conducting interviews and collecting further data from a sample of establishments who were eligible to apply for certificates of authority. However, the returns from the questionnaires were very variable. The return from the Care Commission, for example, suggested that there were only 30 establishments of the 1500 plus registered with them in Scotland which currently had a resident or residents whose finances were managed under Part 4 of the Act.
The returns from the health boards were also very variable, with one health board reporting there were over 90 residents whose finances were managed through the AWI Part 4 to two who claimed there were no such residents.

With such a variation in the returns it was felt necessary to conduct further interviews to explore how Part 4 was being used at health board level. We therefore interviewed representatives from each of the health boards who responded to the questionnaire (n=11. To further clarify the picture, in two health boards we interviewed two representatives from each health board; one who had acted as part of the supervisory body and one who was involved in the day-to-day management of patients funds. This allowed us to gather the views and experiences of both those who had to authorise certificates and those who had to deal with the practicalities of managing patients finances.

The case studies

The quantitative data collected in the first stage was intended to inform the second stage of the research, in which we adopted a more qualitative approach. We constructed case studies in three geographical areas with the aim of assessing in more depth knowledge, uptake and use of AWI Part 4. The three areas selected were those covered by NHS Greater Glasgow and Clyde, Tayside and Highland Health Boards. This would ensure that we included the experiences of those who lived in urban, rural and remote rural areas. It would also ensure that we gathered data that represented the views and experiences of as diverse a group as possible.

In each of these localities we intended to interview representatives from

- the local health board,
- an NHS hospital,
- a private hospital (where they existed)
- three care home services who have applied to manage residents’ finances (one of each run by a private organisation, a voluntary or charitable sector group and a local authority)
- two care homes who had not applied to manage residents’ finances.

We aimed to select these sites so as to ensure that, across the research, views and experiences that reflected the age range and the range of impairment groupings that might be covered by AWI Part 4 were included.

Some changes were made to the case studies due to the difficulty in locating care homes with managers who had experience of managing under AWI Part 4. Firstly, Dumfries and Galloway was included as a case study area to include care home managers with experience of AWI Part 4. Inclusion of Dumfries and Galloway would also provided care homes located in more rural and remote areas. It was also originally intended to include private, independent and private psychiatric hospitals in this study. However, the Care Commission reported that they had received no applications for AWI Part 4 from these sectors (see para 6.5).
In constructing our sample from the care home sector we used a purposive sampling approach. We identified three main groups of individuals who would potentially have their finances managed under Part 4:

- Older people
- People with Learning Disability
- People with mental illness

And care homes from the three sectors, namely:

- Private sector care homes
- Local authority contracted care homes
- Voluntary/charitable organisations

We used web based sources to identify the range of homes across the four health board areas and selected homes so as to ensure all the groups and categories of care homes were included. We initially attempted to do this randomly, however many of the homes contacted either had no knowledge of AWI Part 4 and/or did not want to take part. We therefore tried to identify care homes that did manage residents’ finances under AWI Part 4 and had to be more purposeful in our sampling. After a large number of phone calls we identified 3 care homes which had, or claimed to have, residents with funds managed under AWI Part 4. A total of 11 care home managers were interviewed. Table 3.1 presents an overview of the care homes included in the research.

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Client group</th>
<th>Type of organisation</th>
<th>No of residents</th>
<th>No of Residents AWI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MI</td>
<td>Private</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Older + older MI</td>
<td>Charitable/LA Contract</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Older MI</td>
<td>Private</td>
<td>22</td>
<td>3 residents*</td>
</tr>
<tr>
<td>4</td>
<td>LD</td>
<td>Private</td>
<td>13</td>
<td>7 residents*</td>
</tr>
<tr>
<td>5</td>
<td>Older MI</td>
<td>LA Contract</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>Older MI</td>
<td>Private</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>Older MI</td>
<td>Private</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>LD</td>
<td>Private</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>9**</td>
<td>Older + older MI</td>
<td>Charitable</td>
<td>340</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Older</td>
<td>LA Contract</td>
<td>59</td>
<td>1 previous +2 potential</td>
</tr>
<tr>
<td>11**</td>
<td>Range/ LD</td>
<td>charitable</td>
<td>Care for 2000 over a range of services</td>
<td>0</td>
</tr>
</tbody>
</table>

*question whether under AWI or Appointeeship

** Large organisation with a number of sites interview talking across sites
The interview schedule used with care home managers can be found in Appendix 3.

Interviews with representative groups

3.15 In setting out our research design we felt it was important to present an evaluation of AWI Part 4 that reflected the priorities and experiences of those who might be deemed as lacking capacity and for whom the legislation was designed. However, interviewing such people would not only be difficult and require considerable time, it may also be impossible to get ethical approval for such a direct approach. The interviews with supervisory bodies and establishments authorised under the AWI Part 4 were therefore supplemented with interviews with representatives from a range of organisations of and for disabled people and older people. This consultation included interviews with service providers and ‘expert users’ from organisations who work with people whose finances might be managed under AWI Part 4. It also included individuals from the independent living movement and from organisations for mental health problems, learning disability and older people. Representatives from nine organisations were interviewed as detailed below:

Capability Scotland, Enable, Mental Welfare Commission, the Highland Users Group, National Schizophrenia Fellowship Scotland, Office of the Public Guardian, Crossreach, Alzheimer’s Scotland, Action on Dementia.

3.16 The interviews were conducted either face to face or by telephone and were designed to explore the critical factors they identified in implementing Part 4 of the Act. All interviews were recorded for subsequent analysis.

3.17 The interviews explored:

a) the respondents views on AWI Part 4

b) individual experiences concerns and practical implications of working within the framework of Part 4

c) the perceived benefits and disadvantages of AWI Part 4

d) their understanding of Part 4 of AWI and how it applies to their day to day working practices

e) the strengths and weaknesses of the current approach

f) perceived barriers and drivers to seeking authorisation

g) details of any practice examples relevant to the issue

3.18 All topic guides can be found in Appendix 4 and were submitted to the research Advisory Group for comment before use.

3.19 Interviews and field notes were analysed using standard qualitative methods. We analysed all the interviews using a constant comparative method and
examined and documented emerging and recurrent themes across interviewees, groups and topics of particular importance to the participants.

**Limitations of the research**

3.20 There are a number of limitations to this research. It became clear at an early stage of this research that AWI Part 4 was a very little used piece of legislation. Uptake, as we discuss later, was very low and therefore evaluating some aspects of AWI Part 4, for example, use and effectiveness presented significant difficulties.

3.21 Perhaps the most important limitation of the study and its findings is the very small number of care home managers with experience of using AWI Part 4 that could be identified. We had initially hoped that we would have been able to select care home managers to interview from a centrally held register of all homes with residents whose finances are managed under AWI Part 4. Unfortunately no such register existed at the time of this research and we therefore had to try and track down care home managers with this experience by phoning individual care homes and asking whether they had experience of AWI Part 4.

3.22 None the less, the research involved a range of stakeholders who provided an interesting insight into the knowledge and use of AWI Part 4.

3.23 In 1999, the then Scottish Executive estimated that there would be 100,000 people in Scotland who might benefit from AWI. Given this estimate, the returns from the health boards and from the Care Commission were surprising. We expected much higher numbers of people having their finances managed under AWI Part 4. This low uptake made it difficult to carry out a comprehensive evaluation of the Part 4 of AWI

3.24 This research, plus previous work, would suggest that the figure of 100,000 was either an overestimation of the number of people who could benefit from AWI or that it is not reaching those it was intended to help. This position is not unique to AWI Part 4. Other Parts of AWI, most notably AWI Part 3, also has a very low uptake. When originally planned, it was envisaged that Part 3 would be used by up to 20,000 people per year. Despite recent changes in the legislation that were aimed at making Part 3 more accessible and easier to use, there were just over 320 cases intimated under Part 3 in 2008.

**Summary**

3.25 This chapter has documented the methods used in carrying out this research. It has described the methods employed in both developing and administering the questionnaire that was sent out to all supervisory bodies. It also describes the qualitative element of the research and explains who were interviewed and the selection criteria employed for selecting interviewees. The methods employed in the analysis of the data are also documented.

3.26 The findings from the research are set out in the next three chapters.
4 HEALTH BOARD ANALYSIS

Introduction

4.1 This chapter documents the findings from the health boards and hospitals. It also includes data on uptake of Part 4 for the State Hospital. It begins with a brief overview of the data, looking at the returns from the questionnaire, focussing in particular on the level of uptake of AWI Part 4 across Scotland. It then moves on to explore the health boards’ and hospitals’ views and experience of using the legislation. The role of the Health Boards as supervisory bodies and the experiences of health boards and hospitals in managing the patients’ funds are then explored. The chapter finishes with a review of the health boards’ Codes of Practice and training and their policies and procedures.

Uptake of AWI Part 4 by health boards

4.2 This section discusses the data from the questionnaires returned by the health boards.

4.3 Returns from the health boards were, in some cases, difficult to obtain. Three of the territorial health boards did not reply to the questionnaire, despite repeated requests (Table 4.1). The remaining 11 territorial health boards and the State Hospital did respond although some boards (3) reported that they did not hold data on uptake of AWI Part 4 on a central register and, as a consequence, were unable to complete the questionnaire. Two health boards could only supply data for the current year.

4.4 The ‘route’ which the questionnaire took through the various health boards has provided an interesting insight into who has responsibility for AWI Part 4 across the various boards. It is clear that there are a range of staff within health boards involved in the management of AWI Part 4 and a great deal of variety between health boards. For many health boards, Patients’ Funds Managers were involved in the practicalities of using Part 4 of the Act.

Uptake

4.5 Table 4.1 shows the uptake of AWI Part 4 by each health board area. There was clearly a great deal of variation in uptake between health boards across Scotland. Uptake was highest in Forth Valley and Greater Glasgow. Of the two island health boards that responded, neither managed finances under AWI Part 4.
## Table 4.1: Uptake of AWI Part 4 - NHS hospitals (2006-2009)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>23</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde NHS Board</td>
<td>12</td>
<td>87</td>
<td>62</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>**</td>
<td>**</td>
<td>8</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>26</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>90</td>
<td>71</td>
<td>52</td>
</tr>
<tr>
<td>NHS The State Hospital Carstairs</td>
<td>*</td>
<td>*</td>
<td>5</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*No information provided. ** Incomplete return where a Health Board did not have full data for all hospitals under their remit. NR: Questionnaire not returned.

### 4.6 Differences in population levels alone cannot account for variation between health board areas. Whilst Greater Glasgow and Clyde Health Board does cover the largest population in Scotland and manages the funds of the largest number of people, Lothian, the next largest health board, manages the funds of a very low number of patients. The differences in uptake between Forth Valley and Tayside again suggest that there are other issues influencing the level of uptake in these two health boards.

### 4.7 Findings from the follow up interviews with health board stakeholders suggest that one cause for these differences may be accounted for by the difference in interpretation and application of Part 4 of AWI with regard to the accrual of benefits. While a number of health boards see monies accrued from DWP benefits as falling within the remit of DWP Appointeeship (see Table 4.2 for figures of DWP Appointeeship uptake); others view the accrual of such funds as requiring the use of AWI Part 4. Recent changes in legislation whereby patients no longer lose a large proportion of their benefits on entering hospital have made this a more important issue. This report will examine the implications of this later (Paras 4.36, 4.37 6.32, 6.33) but it is clear that differing interpretations of the use of AWI for accruing benefits has had a major influence on the numbers of patients with finances managed under AWI Part 4.

### 4.8 We had hoped to be able to compare uptake of DWP Appointeeships with AWI Part 4. This has not been possible with the data provided. The low uptake of AWI Part 4 in many health boards made it difficult to carry out such a comparison.
There are of course other issues that may contribute to the variation in uptake between health boards. As can be seen from Table 4.1 Shetland, Grampian and the Western Isles Health Boards have never used AWI Part 4 to manage patients’ finances. The responsible officers in these three health boards suggested that this was due to the unique physical and social environment in which these health boards operated. Respondents pointed to the still strong familial and community bonds that exist within rural and remote rural areas. As a result someone was always available and willing to take on the responsibility of managing the individual’s funds whether through guardianship or POA. This, it was reported, was helped by the proactive actions of community nurses and other community health and social care workers identifying the changing circumstances of, for example, older family members with dementia and outlining the range of options available both to them and to their family or friends. The NHS Highland respondent also noted that family and friends were often involved in areas covered by the Board.

Table 4.2. Uptake of DWP Appointeeship NHS hospitals (2006-2009)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>73</td>
<td>77</td>
<td>61</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>66</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde NHS Board</td>
<td>217</td>
<td>218</td>
<td>157</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>65</td>
<td>60</td>
<td>42</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>**</td>
<td>**</td>
<td>20</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>107</td>
<td>88</td>
<td>71</td>
</tr>
<tr>
<td>NHS The State Hospital Carstairs</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*No information provided. **Incomplete return where a Health Board did not have full data for all hospitals under their remit. NR: Questionnaire not returned.

While the differences in uptake of AWI Part 4 between health boards may be explained in part by different approaches to the treatment of money accrued from benefits and the unique physical and socio-economic circumstances of a few health boards with zero returns; it is clear that throughout Scotland as a whole the numbers of adults for which AWI Part 4 is being used to manage finances was low. The low level of uptake was raised in the follow-up interviews with the health boards. A variety of reasons were given for this low up-take. There was a view that AWI Part 4 was designed to be used only as a last resort and that alternatives, through for example AWI Part 3 were being
utilised. As a result, Part 4 of AWI would be of relevance only to a small number of individuals. Some respondents reported that there were very few people with a private income source without either family or friend or someone with POA. Participants also pointed to the changing provision of care within the NHS since the first drafting of AWI in the late 1980s and early 1990s. The NHS and Community Care Act 1990 and its subsequent amendments coupled with policies and procedures aimed at promoting care in the community have resulted in hospitals’ roles as a site of long-term care diminishing. Some health boards have opted not to register some of their hospitals, especially those dealing with acute patients only, as authorised establishments.

4.11 Opinion amongst NHS respondents was divided on whether use of AWI Part 4 would increase in the future. Respondents recognised that individuals’ finances had become increasingly more complex in recent years, with private pension provision, savings and property ownership becoming more commonplace. Individuals’ awareness of financial issues was perceived to be increasing and it was felt that individuals would be more likely to take a proactive approach to their finances. If this is the case the need for AWI Part 4 might diminish. Others however were of the opinion that, as more people aged with a private pension, especially women, and with finances becoming increasingly more complex, there may be a greater need for AWI Part 4.

Number of people that might benefit from AWI Part

4.12 One of the specific objectives of the research was to provide some insight into the number of incapacitated adults who could potentially benefit from AWI Part 4 but were not doing so.

4.13 The number of people in each health board who have, for example, dementia, learning difficulty or mental health problem could be estimated and an assumption made on how many of these would be deemed incapable of managing their own finances. However, we would also have to estimate how many of these would have a private income source, how many had not signed a POA and how many did not have a friend or family member who could manage their finances for them to estimate how many of these might be eligible to have their finances managed under AWI Part 4. We therefore cannot determine how many patients there could be in each health board area who could benefit from AWI Part 4.

4.14 Similarly, we cannot estimate whether the number of people whose finances were being managed under AWI Part 4 under-represent the number of people who potentially could benefit from the legislation.

4.15 If the 1999 Scottish Executive estimates are accurate however, the figures from this research would suggest that there is a very low level of uptake across Scotland overall. The variation in levels of uptake between health boards suggests that there are considerable differences in the way the legislation is being used between health boards.
Knowledge of and views on AWI Part 4

4.16 In general the health boards were very positive about the spirit of the legislation and it was described as ‘necessary’. For many health boards the passing of the AWI had clarified the position with regard to handling the finances of their patients who had incapacity. They recognised the potential of AWI to enable their hospitals to act for individuals and improve their quality of life. The following quote from a health board manager is typical and illustrates this point:

…it’s not just holding money, it’s not a savings plan, it’s a spending plan as well, you know hoping to give people a good quality of life through the use of their own funds, really right back to the old Incapax, Crosbie Report, you know the principles still apply, even if the paperwork looks different these days

4.17 AWI was seen as a positive step that could be taken to improve the quality of life of a patient. It was not seen as something that could be used to disempower individuals. Just because somebody was declared incapacitated under AWI it did not mean that they had their choices removed from them in all aspects of their lives. Rather it allowed the registered establishments to take action to manage an individual’s finances but at the same time to ensure that they were consulted on how the money was spent, as one respondent observed; ‘it is a balancing act … you protect them as far as you need to but encourage them to make their own decisions, however small they might be’. It was also commented that the legislation could not be viewed in isolation, but had to be viewed and applied in the context of other pieces of legislation such as the Adults Support and Protection (Scotland) Act 2007. It was not used as a first line but as the last option available once all other possibilities had been exhausted. This again may explain the low uptake.

4.18 There was some criticism of AWI Part 4. In particular concern was expressed around the letter of the law with some respondents reporting that it was difficult to interpret. AWI Part 4 was seen as complex and ambiguous in places. One respondent found the legislation to be ‘so cumbersome’ that it encouraged people to find an alternative to using the Act. Whilst AWI Part 4 was designed to be the least restrictive option, it was reported that its use was excluded because of the ‘restrictive nature of the Act’. AWI in general looks to promote the least restrictive option and some informants reported that this meant that they looked to alternative means of managing funds first. The fear was that once somebody was declared incapacitated for the purposes of AWI their options for personal autonomy became restricted.

Use of AWI Part 4

4.19 When asked about their experiences in the use of AWI Part 4, many respondents commented on its complexity and its ambiguity. The following were typical responses from Health Board representatives to that question:

It's not clear how to do it and better to avoid at all costs
I think the aims and objectives of Part 4 are quite well intentioned. I do feel in cases that it’s a paper chase, sort of, sheer hell of a paper chase.

4.20 Respondents reported that not only was Part 4 cumbersome to use, it also took a long time to apply for a certificate of authority. The process of declaring somebody incapacitated was not only time consuming, it also took a long time to complete. It could take up to 15 days for a consultation to declare an individual incapacitated and a further 10 days for the Supervisory Body to award a certificate. This was felt by all to be far too long. This was a particular issue for acute patients who may require a quick intervention:

sometimes younger people who have quite a major episode going on in their life but by the time the nursing interventions and medical interventions say the, the, em, medication or whatever kicks in, you could probably be talking maybe about, a week, possibly ten days and that person’s back to being reasonably compos mentis but, for that period of time, we can’t intervene. [...] It falls on us to intervene and safeguard, on their behalf. I mean, obviously, we can do other things but, you know, we don’t know, withdraw bank cards, all that kind of stuff, from the patient.

This was very difficult for the mental health sector and may be one reason why it is so rarely used there.

4.21 Due to the length of time it took to apply and receive a certificate of authority, AWI Part 4 was felt to be of little value to short-stay patients and did not assist in managing patients’ debts, an issue raised within the Code of Practice. Concern was also raised about the ability to manage finances on short term basis:

I’m sure it’s meant with, eh, all good intention but I think what, it’s certainly, one of the worst things that they, to my mind is the fact that if you need to, to do something and you need to do it quickly you’ve got to wait for all these specified time limits, em, you know, before you can, you know, try, try and manage somebody’s money. You know, if, particularly if it’s an acute situation, you know, where somebody’s maybe spending money out of a bank account, we’ve got no legal wherewithal, at least, until the Certificates done or when we can try and contact the bank. So, all the fifteen working days, ten working days, kind of stuff, you know, for, for me that’s, there should be some way round it, you know, in specific kind of circumstances.

4.22 The difficulty in determining whether someone was incapable of making a financial decision was raised by some respondents as an issue from which larger moral and ethical questions arose about the use of the AWI Act. These were not just about the denial of capacity, indeed this was rarely raised as an issue. It was more about the extent to which the AWI Act could be used. For example we were told of one case where an application for Part 4 was made on the grounds that a patient’s funds were possibly being used by family
members to the detriment of that individual’s savings. The family were using the funds to enable a family member to travel from overseas to visit the patient. The application to manage funds under Part 4 was rejected by the Supervisory Body on the grounds that the person did understand the financial implications of paying for travel for their family member and was happy to do so.

4.23 On another occasion a patient’s solicitors asked for the health board to manage finances under AWI Part 4 in order to save clients the additional expenditure of paying for the services of the solicitor. The Health Board was uncomfortable with this role but it was clearly within the patient’s interests to manage their finances at the lowest cost. The actual duties and responsibilities of the Health Board are not clear in this example.

4.24 The death of a patient whose funds are managed through AWI Part 4 was also raised as an issue. Respondents identified that the Act was not clear on what should happen should a patient die. However, most hospitals had developed their own policies and procedures to deal with this eventuality and it was therefore not deemed to be a substantive issue.

Health boards as Supervisory Bodies

4.25 All health boards who responded to the questionnaire, with the exception of one, had developed and implemented a range of auditing mechanisms to monitor the use of AWI Part 4. These included internal and external audit, and involved both the supervisory body and the patient funds systems. Some health boards have set up systems where they inspect a sample of the authorised premises, normally about a 10% sample. An officer would go to the ward and examine the ward’s records and financial plans. They would also examine the reviews and procedures put in place by each ward, in particular the regular review meetings of the health care team which makes decisions about patient funds. Some health boards have now implemented a thorough review system of AWI Part 4 and are meeting the demands for review as laid out in the Code of Practice.

4.26 There was however a great deal of concern expressed by some of our respondents over the ability of health boards to act as both a Supervisory Body and also to act to oversee the practices of its own employees in this regard. Interviewees pointed to the particular organisational landscape in which the legislation was first developed. In the late 1980s/early 1990s health boards and NHS Trusts were separate entities, one purchased the services provided by the other. The end of the purchases/provider split has meant that the arrangements put in place by the legislation may now not be robust enough. Currently the health boards are carrying out their responsibilities as Supervisory Bodies and whilst this may be working some people are uncomfortable with this arrangement. Some respondents felt that an external body, such as the Mental Welfare Commission or Office of the Public Guardian would be better placed to take on this role. One Health Board manager for example told us that
'nothing concentrates the imagination more than knowing that someone else could be looking over your shoulder and just checking that, all procedures were in place to deal with, you know enquiries'.

4.27 No health boards had received any complaints around AWI Part 4. This may, in part, be explained by the patient group covered by AWI Part 4. It is very unlikely that these patients are going to be in the position to make a complaint themselves and, if Part 4 has been selected, they are unlikely to have any one to act on their behalf. This latter point reinforces the point made in the preceding paragraph.

4.28 Concern was expressed by some of the voluntary sector organisations about the ability of health boards to act as supervisory bodies. They were seen as being very slow to act when the legislation was first passed; knowledge of the Act was also raised as a concern. One respondent felt that Health Boards were more comfortable with the concept of guardianship rather than AWI Part 4. It was also felt that some Health Boards were much more comfortable dealing with DWP Appointeeships and that, as a result of wider policy changes, few officers in Health Boards now have an in-depth knowledge of long term care issues. It is certainly true that in one interview the Health Board officer did get confused with regard to AWI Part 4 and DWP Appointeeships.

Managing funds

4.29 Both Patients Funds Officers and managers were interviewed for this research. These interviews provided an insight into the day to day issues of managing funds and in this section we draw on these experiences.

4.30 Health Boards managed funds through a variety of systems. Some employed what is called a patient funds system. In this system all the funds are pooled into a single account but each individual patient has a personal account within the large single account that generates interest. This not only has the benefit of maximising the amount of interest accrued it also reduces the administration costs, both for the health board and for the individual.

4.31 Other Boards opened individual accounts for each patient. This approach is much more demanding and, it was reported, could lead to difficulties when trying to open new accounts for patients. A number of respondents observed that health boards were in effect providing a free banking service to patients and that this was not one of their core businesses and was something that they were not used to doing nor something they had much expertise in.

4.32 A recurring issue mentioned by Patient Funds officers was the lack of information regarding an individual’s finances available to them. Patient Funds officers were often reliant upon social work, family members or friends to identify whether someone had a bank account or other resources. As they do not routinely visit the homes of patients there is no easy way for hospitals to discover bank account details or to gain access to correspondence from banks and building societies. It is also difficult for hospitals to learn about a
patient’s ongoing financial commitments which can make debt management difficult.

4.33 Once bank accounts had been identified, a number of health boards highlighted the difficulty in accessing bank accounts, particularly Post Office accounts. One respondent noted that dealings with banks were at times restricted by the banks interpretation of section 42 (4) of the AWI which states:

*The authorised persons may make withdrawal from such account or source of funds of the named resident as is specified in the certificate of authority and the fundholder may make payments accordingly.*

4.34 As a result, the respondent was only able to withdraw funds but was unable to manage patients’ accounts. For example, she was unable to stop or establish direct debits or set up new accounts which may be interest bearing:

*[bank] … where they say, well their legal advice was that we can withdraw money but we can’t manage her account.*

4.35 The management of patients’ funds was carried out by a range of individuals within the Health Boards. These included people who identified a need at the ward level. This was usually done by a multi-disciplinary team of health and social care professionals who attended case conferences about individual patients. These meetings could include the patient themselves, family members, friends, ward staff, hospital consultants, social workers and patient fund officers.

4.36 Whilst there were many good intentions in this area, the respondents were mindful of the limitations placed on them with regard to what could actually be achieved and what could be included within the care package of an individual. One respondent described this as potentially a ‘grey area’ which would be discussed during team meetings. Multi-disciplinary team meetings provided an opportunity for staff to think about what things the person may wish to do. This was at times difficult given that the patients were unable to articulate their desires combined with the relatively fast turnover of patients in NHS hospitals. It was sometimes difficult for the ward staff themselves to have the time to fully develop the relationship needed for this work. This prompted one respondent to observe ‘*they* can manage twenty pounds a week but couldn’t manage two hundred pounds a week’.

4.37 Key workers and care staff were viewed as integral in decisions as to how to spend a patients’ money. They would have the in-depth day-to-day knowledge of the person and their likes and dislikes. Examples of the variety of things purchased included clothes, toiletries, hairdressing, aromatherapy, Sky subscriptions and season tickets to football clubs.

4.38 No health board reported that they had disposed of moveable property over the value of £100. Noting that within AWI Part 4 due regard must be given to the sentimental value of items owned by patients; one respondent voiced his
uneasiness at using this part of the legislation, particularly for dementia patients:

'It could be something of absolutely no monetary value but could have a huge emotional attachment for that patient'.

4.39 As already mentioned, managing the funds of patients accrued through benefits proved to be a major area of contention in this research. Section 39 (1) a of AWI Part 4 allows for the management of money other than that generated through state benefits and hence managed under Social Security Contributions and Benefits Act 1992 (c.4). However it is clear that a number of health boards are using AWI Part 4 to manage patient’s funds accrued through benefits. From table 4.2, it can be seen that some health boards act as DWP Appointees for a number of their patients. This decision owes much to recent policy changes which have meant that patients continue to receive benefits during their hospital stay. There has therefore been a rapid increase in money arising as a result of benefit accrual over a relatively short period of time for some patients. Individuals for whom AWI applies may have only limited outgoings and as a result benefits may remain relatively untouched. The Care Commission consider that all monies saved from benefits should be managed through a DWP Appointeeship, a view not shared by some health boards. Respondents were aware of the difference in interpretation of AWI Part 4 from the Care Commission and felt that clearer guidance needs be given on the point at which benefits became savings. One respondent commented:

If somebody’s been in for ten, fifteen years or even longer you cannot hand on heart say that all the money is from benefit because there will be personal monies… there will be interest accrued to the account of the patient, all that type of stuff.

4.40 Health boards differed on this issue. Some did not see benefit accrual as private income and continued to manage funds under DWP Appointeeships whilst other boards applied for an AWI Part 4 immediately. Others chose a cut off point of £500 or £1000 pounds and when savings reached that level an application for a Certificate of Authority was made. Although those Health Boards who opted for AWI Part 4 perceived this to be a reasonable practice, some had encountered difficulties when transferring patients to authorised establishments supervised by the Care Commission. This issue is discussed in Chapter 6 ( paras 6.32, 6.33).

Code of practice and training

4.41 Overall, respondents felt that the Code of Practice for both Supervisory Bodies and managers of authorised establishments had been useful in interpreting the AWI and applying it to the particular circumstances of their health board. Many health boards had consulted the Code of Practice in establishing their policies and procedures for AWI Part 4. In developing their policies and procedures they also built upon systems used under the previous legislation.
4.42 Despite the generally favourable comments directed at the Code of Practice, a number of respondents commented on the difficulty in interpreting the Code of Practice. It was seen by some as being too legal and difficult to apply to the hospital environment.

4.43 Health boards were seen by some of our respondents as being very slow in getting involved with AWI Part 4. It was felt that, initially, they did not produce enough training materials in the area and that their staff were unaware of AWI.

**Policies and procedures for the transfer of patients**

4.44 All health boards who responded to the questionnaire had policies and procedures in place regarding the transfer of patients to other establishments within their health board, to other health boards or localities. Many of these policies were in place prior to the full implementation of AWI Part 4 and owe their origin to policies established as part of the transition process implemented in the closure of long stay institutions. Some health boards have simply modified these policies in developing their current practices:

> ‘We’ve] developed a, kind of, our own way of making sure that the money was transferred. Eh, so we had our own process that, that we carried on with.’

4.45 Despite the existence of these policies many health boards experienced a number of problems in transferring patients to other establishments, particularly care homes. Many of these establishments do not have arrangements in place to manage patients’ finances, whilst some simply refuse to take on this responsibility. Under AWI Part 4 health boards, in their role as a supervisory body, must be sure that adequate arrangements are in place to manage the finances of an individual they are discharging. As a consequence some health boards have continued to manage a patient’s funds post discharge. There is provision under the AWI Part 4 for this, but only for three months. Health boards were exceeding this three month transition period outlined in the Act. This situation is meant to be only temporary to enable funds to be paid to the individual while arrangements were set up. If an organisation refuses to handle such funds, health boards are left with a problem. They can either agree to carry on managing the patient’s finances post discharge or delay discharge. The latter is not a viable option so many have opted for the former.

4.46 Those health boards that have used AWI Part 4 for managing savings accrued through DWP benefit have faced an additional problem. If a care home seeks a Certificate of Authority for such individuals from the Care Commission it is refused because of the differing interpretation of the law in relation to the use of AWI Part 4 for savings from benefits applied by the Commission:

> The Care Commission are saying that they will not issue a certificate [of authority] because [the money] is savings accrued from benefits. As a result we are then holding the monies because we won’t release it
because we have to ensure we are handing over to a responsible party. In cases this is even delaying discharge. Health Board Manager

The difference in interpretation on the use of AWI part 4 in relation to savings from benefits is discussed in more detail in Chapter 6, paras 6.32, 6.33).

4.47 Some health boards have overcome this issue by asking care homes to sign a form of indemnity, acknowledging that they had received funds from the health board. There was some evidence to suggest that discharge was being delayed in some instances. Some respondents reported that reaching agreement on how these monies were to be treated sometimes resulted in delays in discharging patients.

Summary

4.48 This chapter presented the findings from the research into the use of AWI Part 4 by health boards. The data suggest that uptake of Part 4 is much lower than anticipated when the legislation was originally passed. There was also considerable variation in uptake of AWI Part 4 between health boards. A major area of concern expressed by health boards was how to interpret money accrued by benefits. A number of health boards saw such monies as falling within the remit of DWP Appointeeship, a view shared by the Care Commission. Other health boards viewed the accrual of such funds as requiring the use of AWI Part 4. This difference of opinion has created difficulties not just for transfers between health boards but also in discharging patients.

4.49 Knowledge about AWI Part 4 was well disseminated across Health Boards and AWI Part 4 has clarified the position for many health boards with regard how they handled incapacitated patient’s finances. The ideas behind the Act were welcomed and was seen as enabling hospitals to act for individuals and improve their quality of life. When used, the Act was seen as having the potential to improve the quality of life of patients.

4.50 Whilst many Health Boards have developed policies, procedures and monitoring mechanisms in relation to AWI Part 4, concern was expressed about the complexity of the Act and some health boards expressed concern about their suitability to act as a supervisory body.
5 THE STATE HOSPITAL

5.1 The State Hospital, whilst a health board, is different from other health boards and the type of patients it deals with are very different. The duties of the State Hospital include the assessment, treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. It is a national service for Scotland and Northern Ireland.

5.2 The findings in this section are based mainly on an interview with the Medical Officer charged with overseeing the management of patients’ funds.

5.3 The State Hospital welcomed the introduction of AWI Part 4. They see it as a potentially important and necessary piece of legislation but their endorsement of AWI has little to do with patient enablement or empowerment. As an organisation they feel very well versed in AWI in general and feel very comfortable using the legislation. They have implemented a range of staff training on the topic and feel that knowledge is well disseminated throughout the institution. Whilst they feel very happy with the spirit of the legislation, concerns were expressed about its complexity and its bureaucracy. It was seen as being difficult to implement and very time consuming.

5.4 At the time the research was conducted there were five patients in the State Hospital whose finances were being managed under AWI Part 4. However, the relevant hospital administrator felt that the finances of only one of these should be managed under Part 4. The other four patients had accrued savings from DWP benefits and, the hospital felt that the finances of these patients should be managed under DWP Appointeeships.

5.5 Patients in the State Hospital only have very limited opportunity for spending money. They are not able, for example to spend their money on trips, hairdressing, televisions etc. Access to these and other items are controlled or restricted. Patients who continue to receive state benefits whilst resident in the hospital can therefore very quickly accrue considerable sums of money.

5.6 The State Hospital was happy in its role as a Supervisory Body and did not see any potential for conflict.

5.7 The State Hospital had developed a number of policies and procedures in relation to AWI Part 4, in particular it had set up a very extensive monitoring system. This has proved very useful to the hospital, especially in therapeutic terms. As a direct result of changes implemented to meet the demands of AWI Part 4 the State Hospital was more able to check how much was spent and on what by patients with finances managed under that system. It found that many of its patients were “overspending on tobacco and confectionary”. Smoking and obesity were seen as major health problems for patients in the hospital and the hospital felt that they had a duty to try and control these. Under the DWP Appointeeships, the hospital could not easily monitor what their patients were spending their money on. The new monitoring put in place
under AWI Part 4 has allowed them to keep a record of patient spending and this has proved very useful in individual patient case reviews. The hospital was considering extending this monitoring to others on DWP Appointeeships.
6 THE COMMUNITY SETTING

Introduction

6.1 This section documents the views and experiences of those who work in the community setting. It is based mainly on data drawn from interviews with managers of care homes and with the Care Commission. The views and experiences of other organisations are also included where appropriate. Data collected via the questionnaire in the first stage of the study is also presented.

6.2 The community setting is diverse and there are a wide range of organisations offering a variety of services to different groups of people in this sector. The variety of systems and establishments has resulted in a number of different approaches to implementing or working with AWI. Our findings reflect this variety. Whilst we found considerable variation between health boards, differences in this sector were even more apparent.

6.3 As stated in Chapter 4, health boards are now operating in a different social and policy environment than that which existed when the AWI legislation was first drafted. So too are care homes. Many people who would previously have been cared for in hospitals now live in community settings. As a result the care homes are now looking after and provide care and assistance to a much more diverse population many of whom are frail and vulnerable. As a consequence some of their residents for example now have much higher nursing needs than would have existed 10 years ago. There are now many more people who would be defined as incapable under legislation living in care homes and this has impacted on care home practice.

6.4 In selecting the sample of Care Home managers for interview we tried recruit some who had experience of using Part 4, although they were difficult to find. Three homes were identified which claimed to have residents with finances managed under Part 4, however we feel fairly sure that one of these managers had confused Part 4 with DWP Appointeeships.

Use of AWI Part 4 in the community setting

Uptake

6.5 In their return to the questionnaire the Care Commission reported that there were 30 establishments in Scotland with residents whose finances were being managed under AWI Part 4. As with the figures from the Health Boards, these results must be treated with care. The Care Commission reported that their current recording practices make the provision of this sort of data difficult. At the time of the research all Part 4 certificates were issued and recorded locally. Initially, there was no central register of the certificates issued by each of the five Care Commission Regions. However, following a review of this practice, it is intended that a record of all certificates of authority issued will be held centrally at the Care Commission’s head office in Dundee. This should enable auditing to be carried out more easily in the future.
6.6 There were, according to the Care Commission, no residents with finances managed under Part 4 in either independent hospitals or private psychiatric hospitals. This, it was reported, was due to the relatively short length of time patients would reside in such establishments, between two weeks and two months, and the time taken to process an application. One exception to this was provided by the Care Commission where a private psychiatric hospital had applied for Part 4 to manage savings accrued from benefits and protect such funds from the patient’s family. This application was refused on the basis that such funds should be managed under DWP Appointeeship, as the least restrictive option. The Care Commission confirmed that no applications for limited registration had been made by any organisation.

6.7 Uptake of AWI Part 4 appears to be much lower than expected. Given the lack of availability of statistics at the time of the research it is difficult to determine to what extent these figures accurately reflect the use of AWI Part 4 in care homes across Scotland.

6.8 Data from interviews with care home managers, the representative from the Association of the Directors of Social Work (ADSW), the Care Commission, the Office of the Public Guardian and with representatives from voluntary sector organisations would suggest that by far the greatest number of incapacitated adults living in the community have their funds managed through DWP Appointeeships. The representative from the ADSW for example reported “I’m not sure that many of our providers are actually taking up, em, the chance to do it. It is more through DWP”. The representative from Alzheimer’s Scotland felt sure that there were many more people who might benefit from AWI; while other organisations were unsure. One organisation felt that there was one person in one of their homes who may be covered by AWI Part 4 and they were looking in to this.

**Number of people in the community care sector that might benefit from AWI Part 4**

6.9 There are no statistics available that would allow us estimate how many people there are in Scotland living in registered settings in the community with incapacity who would fall under, or would benefit from, AWI Part 4. In 1999 the Scottish Executive estimated that there were approximately 150 patients in Greater Glasgow discharged from hospital ‘without being fully mentally capable’ with a similar proportion in other health board areas. This number was expected to rise by 540 across Scotland in the following year (Thorpe and Wright 1999). These figures would suggest that there is under usage of Part 4 in the community. It is, however, difficult to quantify.

6.10 Estimates can be made of the number of people living in Scotland with dementia, with a learning difficulty or with a severe mental health problem. What cannot be estimated are the number of those who already have awarded a power of attorney, the number of people with a private income source and the number of people who have someone who can act on their behalf. There are too many assumptions to be made to generate meaningful figures and consequently the number of people who may be eligible for and may benefit from AWI Part 4 cannot be estimated from the available data.
Knowledge of and views on AWI Part 4

6.11 Most of the care home managers and owners had at least some knowledge of AWI in general and Part 4 in particular. They had a basic understanding of the principles of the Act and the intentions of Part 4. However, very few had detailed knowledge of AWI and even fewer had experience of either the practical implications of the legislation or of working with the Act. In the interviews very few of our informants were able to discuss the Act in any detail. We were, for example told “I couldn’t tell you what the main aims of the act are because I’ve not sat and read it, but then I’ve never needed to.” Others were even less knowledgeable, “I would have to say, can you actually remind me what Part 4 is?” The data generated in this study suggests that AWI Part 4 is as the Care Commission had suggested very rarely used in care homes.

6.12 Many of the care home staff interviewed, had only been in post a relatively short time. This is typical of staff in this sector, where there is very high turnover at all levels (NCF 2008). It was clear that many of the managers interviewed had had no training in AWI Part 4 and had not had to deal with residents who they considered came under AWI Part 4. All care home managers interviewed felt that more information and more training on AWI would be beneficial. Many felt that current information was inaccessible and was too legal in its approach. It was reported to ‘put off’ rather than help many people. Managers wanted ‘easy to read’ guidelines. Some of the larger care homes or those that were part of a larger organisation had developed their own information on the topic and had leaflets detailing their own policies and procedures for using AWI Part 4.

6.13 There were mixed views on the legislation itself. All those interviewed supported the spirit of the legislation. Managers recognised the importance of AWI Part 4 in protecting and upholding the rights of clients to access monies. They were also aware of the potential Part 4 offered both them and their residents in terms of protection. Those that had used it, or who had some knowledge of the Act, saw it as a good way of ensuring that their residents got access to their funds quickly and safely:

Probably get everything they need quicker than if a relative was involved. If they need new clothes it is possible to speak to the owner of the home and get the necessary funds to purchase clothes. Care home manager

6.14 One care home manager described how he had used the legislation as a way of ‘protecting’ an individual from her own family, who did not give her access to her money and as a result she had no money to spend on hairdressing, clothes, confectionary etc By using Part 4 the manager had put a system in place to ensure that families did not abuse this money and that the money was made available to the resident. Being able to use Part 4 in this case was described as a real benefit.

6.15 The wording of AWI, as in the health sector, was seen as ambiguous, overly complex, difficult to operationalise, inflexible and too demanding. The scale of
the documentation required was described by one respondent as ‘monumental’. The application form is nearly 20 pages long. People felt that they had ‘enough responsibility without taking this on’. Whilst in general many care home managers recognised the potential offered by AWI Part 4, they were loathe to take on both the workload and the responsibility entailed in both applying for a certificate and in managing somebody’s funds. They were aware that if they did not fulfil this role then their residents would not have access to their funds and their quality of life might be affected. However, Part 4 was seen as placing too many demands on them as a manager. It was too complicated for what it gave. This created a dilemma for many of the managers. Respondents told how demands made by the Care Commission were very time consuming and that people working in the registered establishments did not have the time to comply with all the requirements. One interviewee commented:

‘Our staff have backs against the wall as it is, here’s another piece of bureaucracy’

Another insisted

‘I’m a nurse not an accountant’.

Yet another claimed that

“75% of my job as a care manager is doing paperwork we are too focused on paperwork and bureaucracy”.

The Care Commission commented that the complexity of the application procedure was forced on them by the demands of the legislation. The requirements laid out in the AWI were the driver behind the current procedure and until this was changed they could not simplify the process.

DWP Appointeeships were seen as being much less demanding and much easier to use. The representative form the Association of Directors of Social Work made this point eloquently:

People seem reasonably happy as well with the processes that they already had in place. So, in terms of an audit trail, they already have very good audit trails there for administering any money that they are helping with, em, and folks seem happy with that.

These feelings were shared even by those who had residents with finances managed under AWI Part 4. They felt that as long as the numbers were kept relatively low they were prepared to continue but:

I think when you’ve only got say, three residents out of twenty-two that’s okay but when you end up wi, like twenty-three residents out of twenty-three then that would be a, much more a, em, you know, onus
on your shoulders, sort of thing, you know. Em, so, I wouldn’t like to be in the position that I was, em, you know, responsible for twenty-three residents (Care Home Manager)

6.19 There were two care managers who took an opposite view. They argued that the management of financial affairs was a crucial aspect of their notion of care. For these managers, care was not simply about attending to the physical needs of clients but encapsulated a notion of holistic care one which incorporated physical, financial and spiritual matters. Care is ‘not just giving tablets and blowing noses’. AWI Part 4 was seen as being an essential part of this model of care.

6.20 All managers felt that Part 4 was seen as placing too many demands on them and that it was difficult to claim recompense for this work. Costs were cited as a major stumbling block. One reason given for care home not using AWI Part 4 was because they did not get paid for it. Financial management of the scale demanded under the AWI “could be a job in itself”. In theory the legislation does allow care managers to claim back money for time taken to either prepare an application for a Certificate or to actually manage a resident’s finances, but many felt uncomfortable doing this. They felt it would be hard to justify these costs to the Care Commission or other auditor. Typical comments from care home managers included:

We don’t get paid for the responsibility

Surely the social work department should take on this responsibility

The care home is not a legal body to take on that responsibility

6.21 Some care home managers questioned whether providing financial support was part of their contractual duties:

We are part of a contracting culture and as such we are contracted to provide a service to the Local Authority, they are commissioned to do a job and their role is to support an individual, that level of support is defined by the Local Authority in the contract… It should not be [our role] to administer this.

6.22 Respondents reported that not only was the process of applying for a certificate of authority to manage funds too complicated, the process of getting a resident assessed as incapable of managing their own finances was also highlighted as a problem. The process was felt to be cumbersome, time consuming and expensive, with some GPs charging up to £100 for this service.

6.23 Some care home managers also expressed the opinion that local authorities, health boards and the Care Commission could not cope if the care homes started to submit applications for certificates for all those who were eligible to apply. Consequently people who may lack capacity were not assessed, one care home manager reported:
There is a conspiracy of silence; we don’t ask questions, this is held by
the LA, by us and by the private sector. There is an unspoken
understanding. We don’t ask questions.

6.24 When originally drafted AWI Part 4 was intended to be an option of last resort
and it has comfortably achieved that. Many care homes have instituted a
range of policies and procedures which almost seem to be designed to avoid
the necessity of using AWI Part 4. Whilst many of the care homes have no
policies or procedures specifically on AWI Part 4 they do have policies and
procedures for guardianship and actively take steps to encourage their
residents to take out power of attorney. Some homes have procedures in
place that seek to encourage families or others, if anyone suitable can be
found, to manage the finances of residents rather than taking on the
responsibility themselves. This was the practice before AWI Part 4 was in
place and care homes have continued to do this. Care home managers
described how, during the early stages of discussion about entering the care
home, the care home manager would discuss POA or guardianship for
finances and welfare with the potential resident and/or their family. This
enabled the establishment of a POA or guardianship but these were not
initiated until needed. This practice removed uncertainty as all concerned
were then aware of exactly who was handling affairs and in what
circumstances and all could be included in the decision making processes.

6.25 There was some evidence to suggest that some care homes were using or
promoting the idea of Guardianship to circumvent the need to use other
legislation such as AWI Part 4. One large charitable organisation with a
number of care homes for example told us that they always took this route
with their residents and a discussion on Guardianship was part of the initial
assessment prior to admission to the home. The Mental Welfare Commission
and the Office of the Public Guardian interviewees both suggested that there
had been a recent rise in the number of Guardianships.

6.26 We found no indication of care home staff selling off residents’ valuable
assets. Again people were uncomfortable with this part of the legislation. In
order to sell assets managers are required to apply a cost benefit analysis to
weigh up what would be in the best interest for the individual. It is the
discretionary nature of this area of AWI Part 4 that managers struggled with.

6.27 Some of the respondents expressed concern about the potential for AWI to
remove autonomy from the individual. Capability for example reported that
the majority of their clients have some capacity and, as an organisation, they
promote people’s rights. One care home argued that AWI Part 4 went against
its fundamental principles. They adopt what they termed a ‘person centred
approach’ and aimed to support independent living and encourage residents,
where possible to take control of all aspects of their lives. They felt that
through employing these work practices they were able to ensure that all
actions they took were of benefit to the adult. This perhaps reflects a poor
understanding of the legislation. The purpose of the AWI Act is not to
disempower individuals, it is to take steps to promote their quality of life and
this misunderstanding suggests that more information and better training is needed.

6.28 It is important to point out however that despite these misgivings and concerns only one service provider contacted had ‘opted out’ of the Act. All other care providers recognised that they had a duty to keep the possibility of using AWI Part 4 open. They wanted the processes and procedures associated with the management of residents’ finances to be above board and legal. They felt that the principles behind AWI Part 4 protected not only their residents’ rights but also their staff’s. The position of the officer from the organisation who had opted out was that there was ‘no point delving into it at the moment as it was not needed’.

Care Commission as a Supervisory Body

6.29 AWI Part 4 has the potential to place considerable demands on the Care Commission. Unlike the health boards it has to prepare policies and procedures that are applicable to organisations that are not under its direct control. These include organisations drawn from the voluntary sector, the private sector and local authorities who provide services to people with a range of needs. The Care Commission covers the whole of Scotland. They operate in a completely different environment to the health boards and the State Hospital. Despite this, all three have to operate to the same Code of Practice. This was seen by many in the community sector as a major problem with the legislation.

6.30 The Care Commission itself has had to set up its own interpretation of the Code of Practice and its own policies and procedures. This was, they felt, the only way they could satisfy both the work of the organisation and attempt to meet the guidance contained within the Code of Practice. The Care Commission was in the process of revising its guidance and its policies and procedures at the time of the research. It recognised that many of its procedures were complex. They reported that there were currently 16-20 different procedures that could be used depending on the complexity of a case and that complex cases could take from three to six months to process depending on the knowledge of the care manager applying. The Care Commission respondent acknowledged that this could cause concern for care home managers.

6.31 The Care Commission have identified a number of other issues in the Code of Practice. There is for example currently no guidance or procedures for organisations that have previously opted out of Part 4 to opt back in again. And this has been referred back to the Scottish Government by the Commission. There are also no processes in place if a service user dies. There is no obligation placed on the manager for a statement of account neither is there any guidance on ‘statement of authority’ in the event of a death.

6.32 Perhaps the biggest issue that affected this sector was the issue of DWP Appointeeships, which has been discussed previously (Paras 4.39 and 4.40). The Care Commission base their policy and practice on legal advice they
have received. The Care Commission do not issue certificates to manage any funds accrued from benefits:

Where we run into difficulty is for people with learning disabilities who are now in Care Homes and they’ve accrued lots, huge sums of money, eh, and we can’t issue a Certificate for that because most of, or, ninety-nine point nine of the time it’s money accrued from benefits.

6.33 Many of the care homes we spoke to said that they took their lead from the Care Commission, and consequently worked on the principle that all money accrued through benefits should be managed under that scheme, no matter how large that accrual. This has caused a great deal of confusion and concern, especially when dealing with Health Boards.

6.34 Concern was expressed, about the suitability of the Care Commission to act as a supervisory body. Some of the care home managers felt that the Care Commission’s expertise lay in the regulation of care and that they did not have the necessary knowledge base to carry out the role of a supervisory body and they have no experience of financial audit:

‘They are used to scrutinising paper trails but they are not accountants’.

6.35 The Care Commission themselves shared this view although they reported that they do have access to accountants and auditors if required. The Care Commission respondent commented that they ‘have always felt uncomfortable with this role’. They would much prefer to hand this responsibility on to another body, possibly the Office for the Public Guardian.

6.36 Many of the managers of care homes commented on the role of the Care Commission as a supervisory body, although it must be again pointed out that only three of the managers we interviewed had had direct experience of AWI Part 4. It was also at times, difficult to separate out their views on the Care Commission as a supervisory body from their views of the Care Commission in general and their experiences of inspections. The managers views varied and they seem to be dependent on who their Care Commission officer was and their relationship with that officer. Managers were concerned that the Commission was ‘constantly changing the goalposts’. Some people felt that the Care Commission did not have a thorough understanding of the problem and that their particular officer knew as little about AWI Part 4 as they did whilst others reported satisfaction in their dealings with the Commission.

6.37 Some care home managers felt that the Care Commission were very rigid in their application of AWI Part 4 and, as one manager described it ‘very black and white, very clinical’. She went on to say they were unwilling to adapt the rules and were very exact in their interpretation of the legislation. Another care manager wanted to share responsibility for a resident’s finances with another officer in the organisation, but reported that the Commission refused, demanding that only one person could be a signature to an account.
Managing residents’ finances

6.38 This next section looks at how care homes are managing residents’ finances under AWI Part 4. It is important to again note that these data are based on the limited experience of the legislation of 3 respondents.

6.39 Some policies that managers referred to when asked how they made decisions about managing their residents’ finances were based on policies they have developed to help them spend resident’s income where their finances are managed through DWP Appointeeships. It was difficult to separate out these two issues.

6.40 Banking was one of the major issues raised by the care homes in relation to managing residents’ finances. There was a hope that AWI “would be a, a big solution for us in terms of bank accounts and all that and it’s not”. Many respondents reported problems in opening accounts, in managing accounts once opened and in moving money across different accounts in some banks. These concerns related not just to current accounts but also to savings accounts and to other saving schemes such as Individual Savings Accounts (ISAs). There appeared to be some disparity between what different banks could do and were willing to do. There was some evidence to suggest that English banks were less aware of the legislation than their Scottish counterparts. They felt that the banks did not understand the legislation. One manager reported that the bank staff were constantly changing and that it was difficult to build up a relationship with the bank:

trying to get an …account set up so that you are co-signatory, em, is very, very difficult because you need so many forms of identification, you need so many letters from the GP and things like that and the banks just don’t have these type of accounts in place, em, to set them up.

6.41 Under AWI Part 4 an individual’s money must be held in a named account. Managers are not allowed to pool money. This, it was felt, increased workload for a manager if they were managing the finances of a number of residents.

6.42 The actual management of finances was also raised as an issue. Many of the limited number of managers interviewed felt unqualified to make the necessary decisions about where best to place a resident’s money to achieve the best return whilst ensuring that their finances were safe. They did not know what to do with stocks, shares, bonds or other saving schemes and the Care Commission were not in a position to help them. Managing these sorts of finances caused, or could cause, high levels of anxiety. Whereas in hospitals a patient fund manager might be able to draw on the expertise and support of others from within their own organisation, care home managers have to take these sorts of decisions on their own.

6.43 As in the NHS hospital setting, care home managers also expressed concern about the amount of work involved in trying to spend all of a resident’s income. There is only so much that can be spent on hairdressers and
flowers. Many people only have limited needs and wants. Spending a resident's money can entail considerable effort and there was concern expressed about charging for this. One care home manager made the point that if they do not spend the money there is a danger that a resident may accrue enough savings that would take them over the cut off point for benefits and their income might be reduced.

6.44 The care home managers interviewed used a variety of means when trying to decide how to spend a resident’s money. All held individual case conferences, where they invited family members, friends, and relevant health and social care professionals to discuss options. All decisions were based on their knowledge of the resident. It was the view of one respondent that ‘Staff need to know residents inside out in order to be able to make decisions on their behalf’. Managers tried to weigh up the costs and the benefits to be gained for the resident. All managers talked about trying to combine care and finance into one package. They all spent the money carefully and all finances were monitored through the case review with associated key workers.

6.45 Residents' money was used to purchase a variety of goods and services. These included hairdressing, clothes, day trips, outings to the theatre, aromatherapy and satellite television subscriptions (particularly for football). Some care homes used the money to decorate their room in a particular colour, or to buy furniture, in particular specialist furniture such as an electric bed or a reclining chair. Some of these services were provided routinely and occasionally care home managers described how this could cause problems as the legislation specifically rules out charging for services that other residents do not have to pay for. One home reported that they had tried pooling resources to buy a bus, but would not repeat this. There were problems with ‘buying the person out’ when they moved or died.

6.46 Some care homes had looked at paying for befriending schemes where people were paid either to come in to the home and spend time with the resident or, to take them out on trips. However, whilst that these might be recognised as beneficial and could improve an individual’s quality of life some managers expressed concern about being able to justify using money for this. Being able to justify expenditure was another issue raised by the managers. Many had tried to put in place a range of procedures so as to prove that they had spent money wisely. One had even gone so far as to film and photograph activities.

Summary

6.47 This chapter has reported on the findings from the community sector. Our findings suggest that there is very little use of AWI Part 4 in this sector and mirror the findings in the health sector. This low level of uptake meant that few (3) of the twelve care home managers interviewed had any direct experience of using AWI Part 4 and this must be taken into account when reading the findings.

6.48 In general AWI Part 4 was seen as a necessary piece of legislation and the protection it afforded both care home staff and residents was welcomed. The
potential it offered residents was also acknowledged. However, many care home managers felt that the policies and procedures around AWI Part 4 were too complex and too demanding, both in terms of time and resources, again mirroring findings from the health sector. Concern was expressed by care home managers about their ability to claim for their time from the patient's funds, confusion about what they could spend the money on and also whether this duty was part of their contractual obligations. Managers voiced the need for more ‘user friendly’ information, support and training on AWI Act.

6.49 Many of the care home managers interviewed expressed concern about the level of responsibility placed on them by AWI Part 4. They did not feel they had the necessary expertise and skills to manage the clients’ finances. Banks, who might have been able to offer this sort of help, were deemed to have varying levels of awareness of the legislation and as a result care home managers experienced difficulties in establishing and managing bank accounts for residents.

6.50 The role of the Care Commission as a supervisory body was also questioned, both by the Commission itself and by those in the sector.
7 CONCLUSIONS AND RECOMMENDATIONS

Introduction

7.1 In this chapter data from the preceding three chapters are brought together and conclusions drawn from the findings. Recommendations on the future development of AWI Part 4 are also made. In preparing the conclusions and recommendations we have brought together what we consider to be the key findings from the research.

7.2 This research suggests that there are three major problems in the implementation of AWI Part 4.

- the legislation is very complex
- applying for a Certificate of Authority is seen as being burdensome
- there is a great deal of confusion around how accrual of benefits should be handled.

7.3 Knowledge of the AWI Act in general and Part 4 in particular was fairly well disseminated across the relevant organisations in Scotland. Most respondents were at least aware of AWI Part 4 and recognised it as an important piece of legislation. The ideas behind the legislation and the underlying principles of AWI Part 4 were seen as important and most respondents were very supportive of its spirit and applauded its general principles. Respondents in all sectors felt that it not only protected both them and their residents or patients but that it also afforded them the opportunity to take action to improve their residents’ quality of life. By spending money on a wide range of activities people’s stay in hospitals or care homes could be made more enjoyable. There was though, a concern that knowledge about AWI Part 4 was not as extensive as it should be, especially in the banking sector and the wider public. Organisations of and for people who may be affected by Part 4 reporting none or very few enquiries about Part 4.

7.4 There were underlying problems with the implementation of the legislation evidenced by the fact that uptake of AWI Part 4 was not extensive across Scotland and also that there was a great regional variation in uptake. This was found to be the case in all sectors: NHS hospitals, the State Hospital and in establishments supervised by the Care Commission. The level of uptake indicated from our research was lower than would have been envisaged when the legislation was originally proposed. We did not however find any evidence to suggest that there were a large number of incapacitated adults with income other than benefits with no-one to manage their funds and who were not already benefitting from Part 4 of the Act. Neither the Care Commission nor relevant officers in the health boards felt this was the case. The low uptake figures reflect similar findings by previous research into other parts of AWI, in particular Part 3.

7.5 Whilst the broad underlying principles of AWI Part 4 and its aims and objectives were seen by almost all research participants as a very necessary
piece of legislation, the actual workings of Part 4 itself and its implementation were not widely appreciated. The legislation was seen as being ambiguous, difficult to interpret and too complicated to implement. It was considered to be ‘written for another time and place’, and the findings would suggest that it was based on a social care system that no longer operates. Much of the terminology of AWI Part 4 does not fit with the current health and social care sector and the ‘one size fits all’ arrangement of the AWI does not allow for enough flexibility in managing residents’ finances. Difficulties were also reported in setting up bank accounts which required a great deal of supporting evidence such as letters form a GP or other medical professional.

7.6 AWI Part 4 has tried to be all things to all people. It has been written to meet the needs of a very diverse group both in terms of the supervisory bodies and the registered establishments. The Codes of Practice have tried to meet the needs of the health boards, the Care Commission and the State Hospital as well as those of hospitals and care homes, all of which have very different working practices.

7.7 The fact that Part 4 was being used so rarely has made it difficult to evaluate and assess its effectiveness and the extent to which it has benefited adults in care and improved their quality of life. We cannot state whether Part 4 is or is not working or whether it is fit for purpose. The low uptake means it is difficult to make recommendations about whether or not the legislation needs to be reformed. It is fair to say that the evidence would suggest that whilst AWI Part 4 might have had some impact on some health boards, its impact on the care home setting would appear to be minimal. This needs to be borne in mind when reading the following paragraphs.

7.8 Notwithstanding these concerns, there is evidence to suggest that, where used, AWI Part 4 has the potential to improve the quality of life of those whose funds are managed under it. By using powers under AWI Part 4 to purchase a range of goods and services health staff and care home managers were able to enhance residents/patients’ life experience.

7.9 The other key issue to be highlighted relates to the accrual of benefits and the different interpretations of how these monies should be treated. There was wide variation in how AWI Part 4 was being interpreted between and within the various Supervisory Bodies. Interpretation of who is eligible for AWI Part 4 has proved to be a very grey area. The disagreement is not about how people with finances managed under AWI Part 4 should be defined or categorised, but how the accrual of money from benefits be treated and what is the most appropriate scheme under which these funds should be managed. Some health boards and the Care Commission favour the use of DWP Appointeeships, whilst other health boards are opting for AWI Part 4. This is already causing confusion, especially where these two differing views intersect for example, in the transfer of patients from hospital to care home. Evidence from respondents in this study suggesting that this is delaying discharge of patients from hospital and that hospitals are being compelled to manage patients’ funds for long periods post discharge indicates that this needs to be clarified.
7.10 Given the relatively low numbers of people with funds managed under AWI Part 4 it is hard to establish clear accounts of best practice. The different ways that AWI Part 4 has been interpreted has meant that there have been conflicting accounts of practice. In the interviews with health board respondents and care home managers we received often contradictory views of what worked and what did not from the different sectors. Not only was there difference of opinion between the two main sectors, some difference was also apparent within the groups. For those health boards and care homes where AWI Part 4 was more widely used it appeared to work well. There were good systems in place to allocate funds and to ensure that funds were spent appropriately.

7.11 The interview data suggests that one of the reasons why uptake was low was because care homes and some health boards were concerned about the bureaucracy associated with AWI Part 4. It was seen as a complex piece of legislation and difficult to put into practice. It was not regarded as being ‘user friendly’. Implementation of AWI Part 4 was perceived as being very demanding and, in the community sector, too expensive in terms of care managers’ time. It provided a ‘one size fits all,’ inflexible solution. Every penny spent has to be accounted for. It also placed demands on managers that they feel uncomfortable with. People in this sector take on some very demanding roles in the provision of care and are often very happy to do so because they have the necessary skills. Under AWI Part 4 people are being asked to operate outside their area of expertise and specialism. Managing finances was seen as a highly specialised and difficult job. If they get it wrong they run the risk of either harming their residents’ wellbeing or their own reputation. Some did not feel prepared to take on this workload or the associated risk and where possible people were pursuing alternative means to manage residents’ finances.

7.12 The irony is that, under policies and procedures contained within AWI Part 4, managers can set up systems that could protect them from such charges. Many care home managers were already taking quite elaborate steps to try and ensure that their use of residents’ finances could be justified.

7.13 Before we discuss our recommendations we wish to make one further point. If the Scottish Government wishes to take action to amend or redraft AWI Part 4 we feel that there is one issue that it needs to be addressed prior to looking at changes in Part 4 itself - any amendments to AWI Part 4 should be considered in the context of all the other arrangements for managing the funds of adults who lack the capacity to manage their own funds, in particular Part 3 of AWI.

Recommendations

7.14 In light of the findings set out in this report, this concluding section outlines a series of recommendations from the study.

- The management of accrued benefits. The DWP and Scottish Government need to consider the need for clearer advice on how monies accrued from DWP benefits should be handled. The current position is not sustainable and
a lead should be given to direct the supervisory bodies. It is recommended that a limit should be set of say £1000 and when that figure is reached, regardless of the origin of that money; its management should come under the control of AWI Part 4.

- The application procedure should be re-examined. The application procedure is, as it stands, far too complex and time consuming. Whilst under the current demands of the legislation this process is necessary to meet the requirements of the Act, the possibility of changing the legislation to simplify the procedure should be examined. The introduction of a fast track procedure should also be examined so that, in an emergency, action can be taken. This would be particularly helpful for people with a mental health problem, as they are often subject to temporary incapacity during which time they may accrue considerable debts.
- A light touch element should be introduced. Currently many managers are put off AWI Part 4 because of its bureaucracy and ‘one size fits all approach’. Every penny spent under AWI Part 4 has to be accounted for. Some form of risk assessment needs to be included. The possibility of allowing a weekly spend of say £30 without too much paperwork should be examined. A sliding scale could then be adopted, with spends of say between £30 and £100 requiring a greater level of accountability and any spend over £100 should be completely transparent.
- New guidance should be provided on what money can be spent on. This guidance should make it clear that managers of care homes can claim back some costs associated with implementing the legislation and with managing a client’s finances. Information about other services that AWI Part 4 monies can be used for, such as befriending schemes, should also be made clear.
- The suitability of health boards and the Care Commission to act as supervisory bodies should be examined. Representatives from both of these organisations have expressed concern about their roles under the legislation. Neither of these organisations have much experience of the sort of financial auditing required under the legislation. There is also the potential for conflict of interest, especially with health boards. An external body such as the Office of the Public Guardian may be better suited to this role.
- The provision of more publicity and better information on AWI Part 4. There is clearly a need for better publicity in this area, both in the care sector and beyond. Banks should be a main target of any publicity campaign. Given the high degree of staff turnover in these services there will be an ongoing need for continual information in this area.
- Remind Supervisory Bodies of their roles in terms of record keeping. The health boards and the Care Commission have a clear duty to keep and maintain up-to-date records of the certificates they have issued. A simple annual return to be completed and submitted to the Department of Health and Community would ensure that such data were routinely collected and recorded and would enable more effective monitoring.
8 REFERENCES


Scottish Executive (1997) Managing the finances and welfare of Incapable adults

Evaluation of the Adults with Incapacity Act (Scotland) 2000 Part 4

Strathclyde Centre for Disability Research has been asked by the Scottish Government to carry out an evaluation of the Adults with Incapacity Act (Scotland) Part 4.

Your responses to the questions below will enable us to determine the level of uptake of powers to manage residents’ finances under part 4 of the Act and how the Act is operating. Should you have any queries about the questionnaire, please contact Dr Nicola Burns at the address below.

Please return completed questionnaires to Nicola by Friday, 12th December.

Questionnaires can be returned to:
Dr Nicola Burns
Strathclyde Centre for Disability Research
Adam Smith Building
Glasgow
G12 8RT

Email: n.burns@lbss.gla.ac.uk
Tel: 0141 330 4651

This questionnaire is available in large print and electronic formats. Please contact Nicola Burns at the address above should you require an alternative format.
**Use of AWI part 4**

1. Using the table below please:
   - provide a breakdown of the numbers of adults with incapacity and
   - the means by which funds are managed

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2. Using the table below, please provide information on number of individuals for whom your Board are holding funds under Section 94 of the Mental Health Act 1984.

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3. Using the table below please tell us:
   - How many applications for Notes of Authority have been received by your health board since 2003?
   - Of this number how many applications were accepted?
   - Of this number how many applications were rejected?

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<tr>
<th>Year</th>
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4. Please describe briefly the main reasons for rejecting applications for Notes of Authority.

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5. Using the table below please tell us:
   - How many applications for Certificates of Authority have been received by your Health Board since 2003?
   - Of this number how many applications were accepted?
   - Of this number how many applications were rejected?

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<tr>
<th>Year</th>
<th>Applications received</th>
<th>Applications accepted</th>
<th>Applications rejected</th>
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6. Please describe briefly the main reasons for rejecting applications for Certificates of Authority.


7. How many applications to manage funds over £10k using Adults with Incapacity part 4 have you received?

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8. How many applications have been received to dispose of residents’ moveable property of value greater than £100?

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Practice Issues

As a supervisory body, Health Boards have the power to revoke Notes and Certificates of Authority.

9. Have you revoked any Notes of Authority between 2004-2008?
   - Yes □
   - No □

10. If yes, please provide details

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<th>Year</th>
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11. For those revoked in the current (financial) year, has your health board taken over management of finances?
   - Yes □
   - No □

12. Have you revoked any Certificates of Authority between 2004-2008?
   - Yes □
   - No □
13. If **yes**, please provide details

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14. Do you have procedures in place for when a person:

   a) Is transferred to another hospital
      i. within the health board
         Yes ☐  No ☐
      ii. outwith the health board
         Yes ☐  No ☐

   b) Other organisation (e.g. Local Authority care home)
         Yes ☐  No ☐

   c) Dies
         Yes ☐  No ☐

15. Have you had any complaints relating to Adults with Incapacity Act (Scotland) Part 4 since its introduction?

   Yes ☐  No ☐
16. If yes, can you indicate how many in the table below.

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<th>Year</th>
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17. Please describe briefly the nature of complaints received.

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18. How do you monitor the use of Adults with Incapacity Part 4 in your organisation? Please tick all that apply

Internal audit  □
Patient funds   □
Supervisory body □
Other (please specify) □
Thank you for completing this questionnaire. We would be grateful if you would participate in a brief follow-up telephone interview to explore issues covered in this questionnaire in more detail and to discuss your views on the operation of Part 4 of the Adults with Incapacity Act.

Please provide contact details below:

Telephone:
Email:

Please return this completed questionnaire to:

Dr Nicola Burns
Strathclyde Centre for Disability Research
Adam Smith Building
Glasgow
G12 8RT

Email: n.burns@lbss.gla.ac.uk
Tel: 0141 330 4651

Thank you
Appendix Two  Health Board Follow up Interview schedule

Health Boards: Follow up telephone interview

Brief introduction to project, purpose of interview.

1. Can you describe briefly your job title and role within your health board.

2. Discussion around questionnaire return.

3. Is control of part 4 AWI within your remit?

4. What are your general views on this piece of legislation?

5. How do you feel your health board is managing part 4 of AWI?

6. How many staff work on the administration of part 4?

7. What policies and procedures are followed by staff for application of part 4?

8. Are all hospitals in your health board authorised?

9. Does someone in each hospital take responsibility for part 4 or is this managed centrally?

10. Who holds these records?

11. Briefly, how do managers/individuals go about the process of applying for a certificate of authority?

12. Can you describe briefly your review procedures

13. Can you describe briefly your monitoring and recording procedures

14. On what grounds were applications for part 4 rejected?

15. Awareness and use of the code of practice

16. Have you identified any issues which the code of practice does not appear to cover?

17. Are there any issues which you would like to raise?
Appendix Three  Topic Guide for Care Home Managers

1. Information about care home;
   a. respondent’s role in organisation;
   b. who has responsibility for Part 4 within home.
   (Ask for documents which would cover some of this information. Information on type of client, numbers etc from Supervisory body).

2. Awareness of AWI Part 4
   (Main aims, what it’s for?)

3. Any residents with finances managed under Part 4.
   If yes, how many in total?
     Currently?
     Ever?

   If none, can you say why?

   Have you ever managed residents’ finances under Part 4?

4. Are there other residents who could benefit from AWI Part 4 but don’t currently?
   No, continue with question 5

   Yes,
   Why is this?
   Which residents could benefit who don’t currently?
   How are their finances managed currently?

5. Views on process of applying for Note of authority
   What was their experience of the process?

6. Process of application:
   a) how make decision to apply for individual
   b) Medical assessment
   c) Applying for a Certificate of Authority
   d) Factors facilitating/hindering process

7. Management within home:
   a) how managed within home
   b) Decisions on what to spend on, who, what?
   c) Procedures to monitor use
   d) Procedures to for complaints
   c) Facilitators/barriers
8. Examples of how benefitted residents? How could be further improved?

9. Monitoring by Supervisory bodies
   Whether received any complaints? (from whom, about what?)

10. Limitations to Part 4
    Individual/family?/staff org

11. How could be improved for:
    Resident?
    Care home

12. Role and support of supervisory body?
Appendix Four  Topic guide for representative organisations

Interview with Organisations

1. Can you describe briefly your job title and role within your health board.

2. What are your general views on this piece of legislation? Probe for understanding of Part 4 and how it applies.

3. Individual experience, concerns and practical implications of working within the framework of Part 4
   - Understanding of part 4 and how it applies
   - Strengths and weaknesses of current approach
   - Perceived barriers and drivers to seeking authorisation
   - Practice examples of relevance

4. Perceived benefits and disadvantages of the Act

5. What do you think are the main issues regarding part 4 for:
   - Your organisation?
   - Care homes/ other institutions?
   - Families/carers?

6. Could you describe how it tends to operate across various organisations?

7. Are there differences between areas?

8. Are there differences between organisations?

9. How do you think care homes are responding to Part 4 of AWI, (probe on how to evidence this? Staff training, contact with care commission: do they provide any training/ support)

10. Are there any issues you would like to raise?