

# Deprivation of Liberty Safeguards: Usage in Hospitals

emias is a member of:



NHS AUDIT ENGLAND  
NHS employed internal audit providers  
Working together for the NHS

Contents	Page
Glossary of Terms	2
Executive Summary	4
Findings – Preliminaries	12
Findings – Internal Processes	13
Findings – Applications Made	19
Findings – Outcome from Applications	29
<u>Appendices</u>	
Appendix A: Findings – Acute/Community Trusts/Hospitals	34
Appendix B: Findings – Mental Health/Learning Disability	39
Appendix C: Consent/MCA Flowchart	44
Appendix D: MCA/DoLS/MHA Flowchart	45

This work was undertaken by Elaine Dower, Assurance and Development Specialist. Any query concerning the content of this review should be made to Elaine Dower on 07703 716968 or [Elaine.Dower@emias.nhs.uk](mailto:Elaine.Dower@emias.nhs.uk).

**Application for Authorisation** – Managing authorities must submit an application to the relevant supervisory body where it appears to the managing authority (Trust/Hospital) that the relevant person is, or is likely to be, detained in a hospital for the purpose of being given care or treatment in circumstances which amount to a deprivation of liberty and is likely to meet all of the qualifying requirements. The supervisory body will then arrange for assessments to be completed by appropriately qualified individuals to ensure the individual for whom the application is being made does meet all of the qualifying requirements:

- the age requirement;
- the mental health requirement;
- the mental capacity requirement;
- the best interests requirement;
- the eligibility requirement; and
- the no refusals requirement

If all of the assessments are positive and received in writing by the supervisory body then they will authorise or ‘grant’ the deprivation of liberty to be undertaken by the managing authority.

An application to the supervisory body is generally documented by completing Department of Health ‘**Form 4**’, although the forms produced by the Department of Health are ‘standard’ rather than statutory and therefore some Trusts/Hospitals have developed their own forms. The CQC must also be informed of all applications made to the supervisory body.

There are primarily 3 situations in which a managing authority will submit an application for authorisation to a supervisory body: Urgent Authorisation + Application, Standard Application and Repeat Application, each of which are described below.

**Urgent Authorisation + Application** – When it is believed someone is already being deprived of their liberty in their best interests in order to provide them with the care and treatment they need, the managing authority is able to grant itself an Urgent Authorisation for up to 7 days. The managing authority will generally complete Department of Health ‘**Form 1**’ to put this authorisation in place (although some Trusts/Hospitals have developed their own forms). Because the completion of the relevant Urgent Authorisation form (normally Form 1) provides up to 7 days authorisation to deprive someone of their liberty in their best interests to provide them with care and treatment, the signing of this form is very significant both for the patient and the managing authority on whose behalf it is signed. We would anticipate that the managing authority would only wish to enable/allow staff to sign this form (and therefore authorise a short-term deprivation of liberty and breach of the patient’s article 5 right under the European Convention on Human Rights not to be deprived of their liberty) if they have received specialist training in the Mental Capacity Act and the Deprivation of Liberty Safeguards (i.e. above and beyond the training afforded to clinical staff en masse).

In situations where managing authorities grant themselves an Urgent Authorisation they must

also submit an Application for Authorisation (normally by using Form 4) to the supervisory body. In this situation, because there is already an authorisation in place but only for up to 7 days, the supervisory body must complete their assessments and determine the outcome of the application within the 7 day period. Throughout this report we have therefore referred to an Urgent Authorisation accompanied by an Application for Authorisation as an 'Urgent Authorisation + Application'.

**Standard Application** – When an Application for Authorisation (normally Form 4) is submitted to the supervisory body by itself (in advance of a patient potentially being deprived of their liberty) it is referred to throughout this report as a 'Standard Application'. An application can be made up to 28 days prior to the date on which it is believed the potential deprivation of liberty will commence. All assessments must be completed and the authorisation granted or refused by the supervisory body within 21 days.

**Repeat Application** – Often referred to as a 'renewal' application, this is referred to in the legislation as a 'further authorisation' (paragraph 29 of Schedule A1). The process of application, assessment and authorisation is the same as for a Standard Application but the application is made in respect of someone who is already subject to an authorisation and the application requests a further authorisation that will come into effect immediately following the expiration of the current authorisation period. Repeat Applications are therefore a sub-set of Standard Applications but throughout this report we have separated them out as a distinct category. In this report we have used the terminology 'Repeat Application' as 'renewal' might imply that the process is merely a rubber-stamping exercise to prolong current authorisation periods, which clearly is not the requirement.

## Introduction & Background

The Deprivation of Liberty Safeguards (DoLS/'the Safeguards') were added to the Mental Capacity Act 2005 by the Mental Health Act 2007. The Safeguards came into effect in April 2009 with the aim of preventing breaches of Article 5 of the European Convention on Human Rights, as had been found in *HL v UK*<sup>1</sup> (known as the Bournemouth case).

As 'managing authorities' under the Safeguards, NHS Trusts and Independent Hospitals have a legal duty to request a DoLS authorisation from the supervisory body (the relevant PCT until 31<sup>st</sup> March 2013 and then, from 1<sup>st</sup> April 2013, the relevant Local Authority<sup>2</sup>) in any situation where it appears to the managing authority (Trust/Hospital) that the relevant person is or is likely to be detained in a hospital for the purpose of being given care or treatment in circumstances which amount to a deprivation of liberty and is likely to meet all of the qualifying criteria:

- Age requirement: aged 18 or over;
- Mental health requirement: suffering from a mental disorder (any disorder or disability of the mind);
- Mental capacity requirement: lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital for the purpose of being given the relevant care or treatment;
- Best Interests requirement: is detained in circumstances amounting to a deprivation of liberty, the deprivation of liberty is in best interests, deprivation is necessary to prevent harm and the deprivation is a proportionate response to the likelihood and seriousness of the potential harm;
- Eligibility requirement: not excluded from the Safeguards by being subject to detention under the Mental Health Act 1983 or meeting the criteria for detention under the Mental Health Act 1983 and objecting to some or all of the proposed care or treatment for mental disorder; and
- No refusals requirement: no valid refusal of the proposed care or treatment has been made by an Advance Decision to Refuse Treatment, a Lasting Power of Attorney or a Court-Appointed Deputy.

The supervisory body then conducts 6 assessments (against the qualifying criteria) and determines whether to grant or refuse authorisation of the deprivation of liberty.

Failure to comply with the Safeguards may result in civil litigation against Trusts/Hospitals, as well as claims of breach of the European Convention on Human Rights. Trust/Hospital Boards therefore require assurance that appropriate steps have been taken to implement and monitor application of the Safeguards to ensure compliance.

---

<sup>1</sup> European Court of Human Rights [HL v UK 45508/99 \(2004\) ECHR 471](#)

<sup>2</sup> Care Homes are also managing authorities under the Safeguards and already submit their applications to the Local Authority

Prior to the implementation of the Safeguards the Government completed an Impact Assessment to estimate the impact and resource requirements. This assessment suggested a potential 21,000 applications in 2009/10 (4,200 (20%) in respect of people in hospitals), with around 5,000 being authorised following assessment. The total number of applications was expected to reduce each year and level off by 2015/16 at 7,000 applications per annum, resulting in 1,700 authorisations. The reduction and levelling off was expected as people became more knowledgeable about the Safeguards and their implementation and were not therefore submitting applications in respect of large numbers of individuals subject only to *restrictions*. An authorisation rate of 25% was anticipated, as it was expected that people would be cautious and keen to protect this vulnerable group and submit applications where there was any doubt or uncertainty.

The Care Quality Commission (CQC) monitors the operation of the Safeguards<sup>3</sup>. CQC inspections of NHS Trusts continue to highlight that staff knowledge and understanding of the Safeguards falls below expectations. Figures produced by the Health and Social Care Information Centre (HSCIC)<sup>4</sup> also demonstrate that the numbers of applications remain below that originally anticipated by the Government in their Impact Assessment (although the number of applications has risen year on year).

Within the East Midlands we established, facilitate and chair a CQC Benchmarking Forum at which the CQC leads from each NHS provider organisation can discuss their experiences and share best practice in terms of the methods and tools they use for generating assurance of compliance at all levels of the organisation. During a discussion at this forum regarding compliance with CQC Essential Standard 7 (safeguarding), it was identified that healthcare providers find it difficult to gauge whether they are making an appropriate and proportionate number of applications given their size, patient numbers and services delivered.

The group reviewed the two primary sources of information about the use of the Safeguards: The Health & Social Care Information Centre and the CQC.

Supervisory bodies are required to make mandatory returns to the Health & Social Care Information Centre (HSCIC), providing aggregated figures on the number of applications for Deprivation of Liberty Safeguards authorisations they have received and the outcomes of the subsequent assessment process.

---

<sup>3</sup> Regulation 18 of the *Care Quality Commission (Registration) Regulations 2009* requires providers to notify the CQC of all applications to deprive an individual of their liberty under the DoLS. This is translated into Outcome 20 of the Essential Standards of Quality and Safety guidance published by the CQC. In addition the *Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009* make clear that the CQC “must monitor the operation of Schedule A1 in relation to England” and “report to the Secretary of State on the operation of Schedule A1 in relation to England as the Secretary of State may from time to time request”

<sup>4</sup> The HSCIC are currently a Special Health Authority, and will become an Executive Non-Departmental Public Body (ENDPB) in April 2013 as set out in the Health and Social Care Act 2012. They “collect national data from a range of health and care organisations, analyse it and present it in a range of easily accessible formats to help commissioners make better decisions about care and local providers improve their health care services”

On the basis of the information provided by supervisory bodies, the 2011/12 annual report produced by the Health & Social Care Information Centre gives information on:<sup>5</sup>

- The total number of applications each year (+broken down by supervisory body type e.g. PCT and Local Authority);
- The proportion of applications authorised (+broken down by supervisory body type);
- The number of people subject to a standard authorisation at the end of the quarter (snapshot);
- The length of authorisation periods (+broken down by supervisory body type);
- Regional variations in application rate;
- The proportion and rate of applications by age bracket;
- Rate of applications by ethnic group, gender and disability type;
- The proportion of applications not authorised for each potential reason (+broken down by supervisory body type); and
- Number of cases where application not authorised but a deprivation of liberty was thought to be occurring (+broken down by supervisory body type).

The data, as reported to the HSCIC, has consistently been aggregated to supervisory body level and therefore the information cannot be further broken down to identify the number of applications per managing authority and/or size or type of provider<sup>6</sup>.

Managing authorities are required to notify the CQC of all applications they make to supervisory bodies under the Deprivation of Liberty Safeguards and the outcomes from these applications. The CQC produces an annual report on their monitoring of the operation of the Safeguards. As part of the 2010/11 annual report<sup>7</sup>, the CQC compared the number of notifications of applications they had received from managing authorities against the number of applications reported to the HSCIC by supervisory bodies over a nine month period. Of the 7,165 applications reported by the supervisory bodies in the time period, the CQC had received notification of only 2,297 (32%)<sup>8</sup>.

So whilst the data held by the CQC could be analysed in terms of the number of applications made by Trusts/Hospitals of different sizes and/or types, the information they hold is incomplete and as a result the CQC have not analysed or broken down their data in this way.

---

<sup>5</sup> 2012/13 was the first year in which more frequent (i.e. quarterly or 6- monthly) statistics were not published and therefore data relating to 2012/13 was not available at the time of publication.

<sup>6</sup> The provisional Information & Guidance for the 2013/14 DoLS return published by the HSCIC indicates that from April 2013 supervisory bodies will provide individual case level information to the HSCIC on an annual basis.

<sup>7</sup> The 2011/12 Annual Report was not available at the time of publication.

<sup>8</sup> We have been advised that the rate for 2011/12 is somewhat improved, although we have not had access to the detailed information.

The conclusion of the group was that there is limited information available to support managing authorities (as well as supervisory bodies and regulators) in assessing and benchmarking their own practice in respect of the Safeguards.

It was therefore agreed that we would develop a survey for distribution to as wide an audience as possible with the aim of capturing information from health providers that would enable analysis of the rates of applications in providers of different sizes and types (e.g. mental health hospitals, acute/community hospitals, learning disability services). We worked with Executive and Operational DoLS leads in developing the survey to ensure that the output would be as meaningful and useful as possible.

Although the original remit of the work was to cover the East Midlands, it was quickly identified that this work would be welcomed nationally and national coverage would also enhance and strengthen the benchmarking information produced. The survey was therefore distributed by post to the 'Deprivation of Liberty Safeguards Lead' at all NHS Trusts (including Foundation Trusts) and Independent Hospitals in England (241 Trusts and 195 Independent Hospitals). The survey was also available online and was promoted in the December 2012 Browne Jacobson Health Law Newsletter. NHS Audit England<sup>9</sup> members were also asked to promote the survey in their regions and the national SHA safeguarding leads meeting received a copy, again with a request to support and promote completion of the survey in their regional hospital providers.

The survey asked for information about the number of DoLS applications in different categories, the authorisation rate, and reasons for non-authorisation and the length of authorisation periods across the 18 month period 1<sup>st</sup> April 2011 to 30<sup>th</sup> September 2012.

36 Trusts/Hospitals returned useable data (2 of these did not provide any information about the number of DoLS applications or the outcomes). A further 22 commenced the survey online but did not provide sufficient useable data for us to use in the survey results.

The 36 useable returns were from the following regions:

- East Midlands – 9
- East of England – 1
- London – 3
- North West – 12
- South East – 2
- South West – 2
- West Midlands – 4
- Yorkshire & Humber – 3

We have not provided a list of the Trusts/Hospitals who took part to protect their anonymity.

As completion of the survey was not mandatory, it is possible that those Trusts/Hospitals who attach the greatest significance or importance to DoLS provided responses, whereas those

---

<sup>9</sup> Audit England is a group comprised of NHS internal audit consortiums from across England. Between the members, the group provides internal audit services to approximately 70% of the NHS Trusts in England.

where knowledge and understanding remains weakest saw little benefit in further information on DoLS.

## Key Findings

We are very grateful to all those Trusts/Hospitals who provided information. Whilst the sample size is small (8% of Trusts/Hospitals in England), the returns have provided some interesting findings that give rise to topics warranting further investigation. A summary of the key findings is provided below:

- A large number of staff are permitted by their organisations to authorise an urgent deprivation of liberty without necessarily completing advanced, specialist training, therefore potentially breaching patients' Article 5 rights;
- Some Trusts/Hospitals are not maintaining accurate central figures on the number of applications made, the age, gender, disability, outcome and length of authorisation (as they are legally required to) for the purposes of monitoring, identifying weaknesses and improving;
- As reported by the Care Quality Commission, not all Trusts/Hospitals are reporting applications to the Care Quality Commission as they are legally required to (this may be due to a combination of large numbers of staff completing and submitting applications and no central overview and scrutiny of the process);
- There is a difficulty with the terminology around the 'disability type' causing the patient's current incapacity (physical disability, mental health or learning disability) and this may lead to misinterpretation and misleading/meaningless national figures;
- The overall rate of Urgent Authorisations (+ Applications for Authorisation) (across all Trusts/Hospitals who responded to the survey) was 8.3 per 100,000 bed days and in the 18 month period examined: 1 Urgent Authorisation was applied for every 39 inpatient beds;
- Overall across the 18 month period examined, for every 3 Urgent or Standard Applications which were authorised, 1 Repeat Application was subsequently made (i.e. for a third of all authorised initial applications a further repeat application is made to continue depriving the individual of their liberty);
- A large number of applications were not authorised due to the patient having capacity when assessed by the Best Interests Assessor, suggesting either the patient has fluctuating mental capacity (in which case DoLS may not be appropriate) or a lack of robust capacity assessment undertaken by the Trust/Hospital prior to the application being made;
- There are some surprisingly long authorisation duration periods in non-learning disability settings, which may suggest all measures are not being taken to reduce restrictions and/or it is not being considered whether hospital remains the most appropriate environment to meet the patient's needs.

We have further broken down the data supplied into Acute & Community Trusts/Hospitals and Mental Health & Learning Disability Trusts/Hospitals. As the findings and conclusions were similar to the aggregated data set we have not generated separate findings, but have included the data tables in **Appendices A & B** respectively for information and benchmarking purposes.

We have also included, at **Appendices C & D**, two flowcharts developed by emias for training purposes which cover use of the Mental Capacity Act and its relationship to valid, informed consent and use of the Mental Health Act.

## Questions For Consideration

In order to support organisations to make full use of the findings, we have developed a series of questions Trust/Hospital Boards, Quality Committees and Deprivation of Liberty Safeguards leads may wish to consider to assure themselves that the Legislation, Regulations and Code of Practice are being followed appropriately within their organisation.

Report Heading	Question for Consideration
<b>Preliminaries</b>	Have you verified and confirmed the service types you provide as per the CQC Essential Standards guidance and informed the CQC of any amendments required?
<b>Internal Processes</b>	Have all staff who are permitted to complete DoLS Urgent Authorisations + Applications received specialist training?
<b>Internal Processes</b>	How are you assured that Urgent Authorisations and all Applications for Authorisation are being appropriately completed and all regulatory requirements are met, particularly where large numbers of staff are permitted to complete these forms?
<b>Internal Processes</b>	Is the range of job roles of staff able to complete the Urgent Authorisations and all Applications for Authorisation appropriate?
<b>Internal Processes</b>	Do staff completing the authorisation and application forms receive support and scrutiny to ensure authorisations and applications are appropriate and consistent?
<b>Internal Processes</b>	Is specialist knowledge available locally within divisions/specialties to provide support and scrutiny?
<b>Internal Processes</b>	Are further steps required to enhance the identification of potential deprivations of liberty, such as further training for clinical staff or having specialists available within each clinical directorate/ division?
<b>Applications Made</b>	How does your rate of applications per 100,000 inpatient bed days or number of inpatient beds compare to the indicative figures?
<b>Applications Made</b>	Could any of your Urgent Authorisations + Applications have been predicted and therefore been Standard Applications, as should be the case wherever possible?

<b>Applications Made</b>	Do you record information on all applications broken down by age, gender and disability type to enable review and benchmarking?
<b>Applications Made</b>	Are you assured that the disability classifications are being applied consistently across the organisation?
<b>Applications Made</b>	For applications that have been authorised, is a robust system of monitoring and scrutiny in place, in an attempt to ensure that restrictions are reduced and therefore Repeat Applications are minimised, including consideration of whether hospital remains the most appropriate environment in which to provide care and support to the individuals?
<b>Outcomes from Applications</b>	What proportion of your applications were not authorised because the patient was discharged prior to the assessments taking place and therefore may not have been an appropriate application?
<b>Outcomes from Applications</b>	Do you record the outcomes from all applications, including the reason for any non-approvals/rejections and the total time period of granted authorisations?
<b>Outcomes from Applications</b>	Do the reasons for non-authorisation inform your training plan for staff?
<b>Outcomes from Applications</b>	How many of your authorisations last for more than 30 days? Are you assured that in respect of these authorisations all methods of reducing restriction have been considered and utilised?
<b>Outcomes from Applications</b>	Have staff received training in the possible ways to reduce restrictions on patients and therefore avoid deprivations of liberty?

Whilst this report is produced primarily for Trusts/Hospitals, we anticipate that it will be of interest and use to a variety of agencies. The report contains a considerable amount of data in the form of tables and charts, much of which we have not tried to draw conclusions from but present simply as information against which organisations can benchmark themselves.

Copies of the full report and the Executive Summary are available on our website: [www.emias.nhs.uk](http://www.emias.nhs.uk).

If you have any queries regarding the content of this report or would like to discuss any aspect of your assurance mechanisms in relation to DoLS, please do not hesitate to contact Elaine Dower, Assurance & Development Specialist, [elaine.dower@emias.nhs.uk](mailto:elaine.dower@emias.nhs.uk), 07703 716968.

Our thanks go to Browne Jacobson Solicitors for promoting involvement in the survey.

Thanks also go to Rachel Griffiths (Mental Capacity Act Development Manager for SCIE) for supporting the survey, providing sage words of advice and helping to shape the report.



## Findings - Preliminaries

We asked participants to identify the service types they provide, as defined by the CQC Guidance 'Essential Standards of Quality & Safety'. As reported in our 2011 CQC Benchmarking report, there appear to be inconsistencies in the way hospitals are registered with the CQC for the types of service they deliver. There were several instances in the returns where Trusts/Hospitals ticked the 'MLS' service type (hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse) but yet did not have any designated mental health or learning disability beds. Whilst this may be explained by acute/ community Trusts/Hospitals wanting to ensure that the care they provide to patients with dementia is properly recognised, there were examples of acute/ community Trusts which have older people's wards (and therefore will also care for dementia patients) who had not identified MLS as a service type. In addition, the CQC's own guidance does not indicate that this service type should extend to cover the provision of services to people with dementia in acute/ community hospital environments. There was also an instance where the Trust stated a figure for the number of in-patient days accounted for by patients detained under the MHA and yet did not include 'MLS' in the list of service types they provided.

### Preliminaries – Questions for Consideration

- Have you verified and confirmed the service types you provide as per the CQC Essential Standards guidance and informed the CQC of any amendments required?

## Findings – Internal Processes

We asked participants a series of questions about the internal processes within their organisation in respect of how many people at what level can complete the DoLS application forms and what internal support or advice is available to them. A summary of the findings is provided below.

### **How many people can complete forms?**

*(33 Trusts/Hospitals answered this question)*

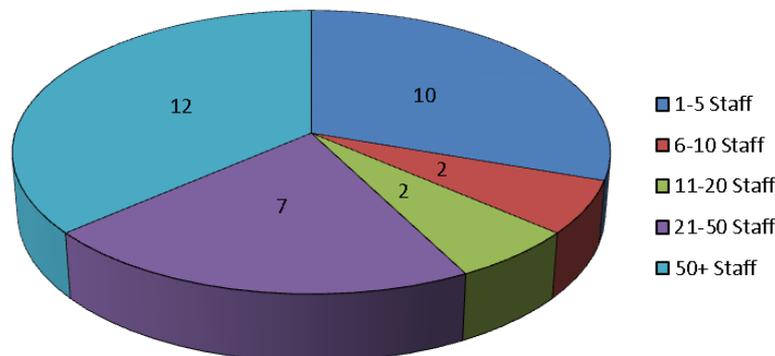
As indicated in the glossary, we anticipated that only a small number of staff in any organisation would be permitted to complete the Form 1 (or equivalent alternative), as this authorises the deprivation of liberty of a patient (for a maximum of 7 days) and therefore has great significance for the patient and legally for the Trust/Hospital. We anticipated that a larger number of people would be permitted to complete the Form 4 (or equivalent alternative) on behalf of the Trust/Hospital as this would promote use of the Safeguards, raise awareness amongst staff and would not have any immediate significant implications as full assessment would precede any interference with article 5 rights.

However, in only three Trusts/Hospitals did the number of people who could complete the two forms differ in the expected way, with more people permitted to complete Form 4 (or equivalent) than Form 1. In two cases the number rose from 1-5 who could complete Form 1 to 50+ who could complete Form 4. In the third case the number rose from 1-5 for Form 1 to 6-10 for Form 4.

In one further Trust/Hospital the number of staff who were permitted to complete Form 1 was actually greater than the number of people who could complete Form 4.

For the vast majority (88%) of Trusts/Hospitals, therefore, the number of staff who are permitted to complete each form is the same, with the numbers of Trusts/Hospitals in each staff number range represented in the chart below (for the purposes of the 4 Trusts identified above, the figure represented is the Form 1 figure as this is the most significant in terms of implications):

Number of Trusts/Hospitals allowing different numbers of staff to complete an Urgent Authorisation



Of the 10 Trusts/Hospitals who indicated that 1-5 staff could complete the forms, 2 indicated that only 1 person could complete the forms. This may represent a risk in terms of availability.

6 of the 12 Trusts/Hospitals in the 50+ bracket, further indicated that over 100 staff could complete. One Trust/Hospital indicated that over 500 members of staff could complete the Urgent Authorisation and Application forms (both Form 1 and Form 4).

Only 5 Trusts/Hospitals indicated that any medics were able to complete the forms.

17 out of the 21 Trusts/Hospitals who indicated that over 11 people were able to complete the forms included ward managers and/or nurses in charge of the ward.

The greater the number of people able to complete the forms, the greater the risk that:

- Applications will be made inappropriately as staff do not have the necessary level of knowledge and understanding and therefore patients' human rights will be breached;
- Forms will not be completed correctly, leading to delays in the process;
- Forms will not be sent to the supervisory body, meaning deprivations of liberty will not be lawful;
- The CQC will not be notified of the application;
- The Trust/Hospital management will not be aware of all applications being made and therefore will be unable to identify trends, themes or weaknesses; and
- There will be inconsistency in the comprehensiveness of forms, making the job of the assessors more complex.

These risks need to be balanced with ensuring:

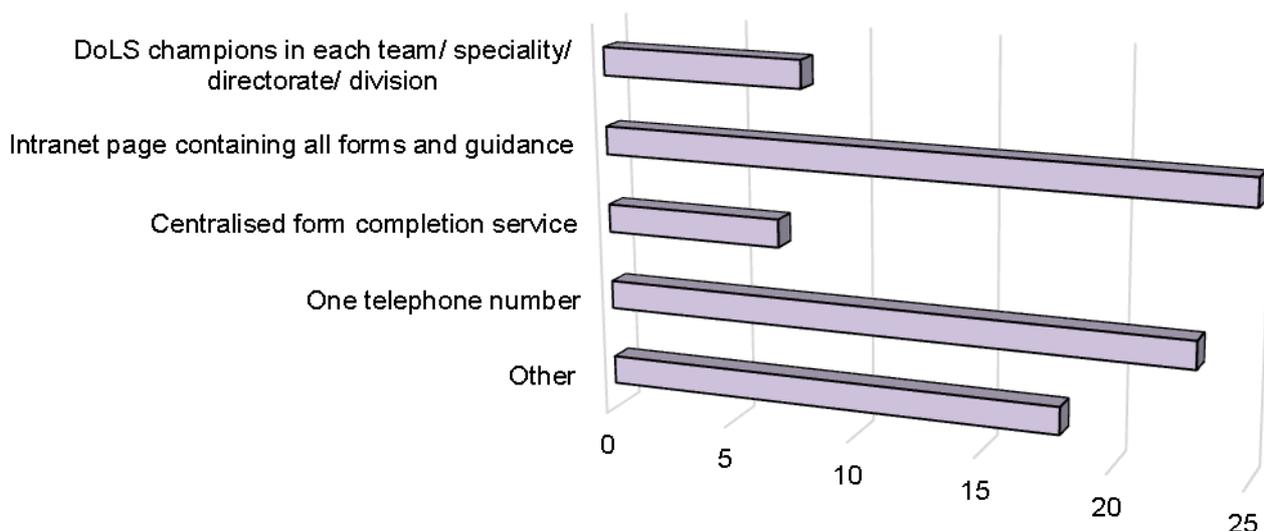
- Sufficient people are available to complete the forms to ensure patients potentially being deprived of their liberty are afforded the proper safeguards; and
- Staff providing care and treatment to patients do not feel alienated from the application process and assume it is someone else's responsibility.

### Systems in place to support staff in following process

*(32 Trusts/Hospitals answered this question)*

We asked participants to select from a pre-determined list the systems they had in place to provide support and advice to staff and to ensure that all legal and regulatory requirements were met.

Methods of Support

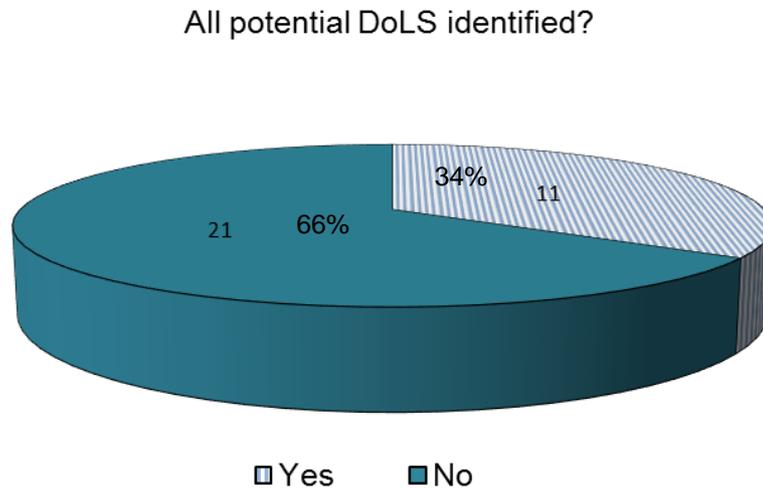


Of the 18 Trusts/Hospitals who selected ‘other’ the specifics provided mostly identified that a Mental Capacity Act and/or Safeguarding lead could be contacted for advice as required and/or that a policy and screening tool was in use.

The low number of Trusts/Hospitals with a centralised form completion service correlates with the large number of Trusts/Hospitals who have a significant number of staff able to complete the application forms.

**Do you believe that all potential DoLS within your organisation are being identified?**

*(32 Trusts/Hospitals answered this question)*



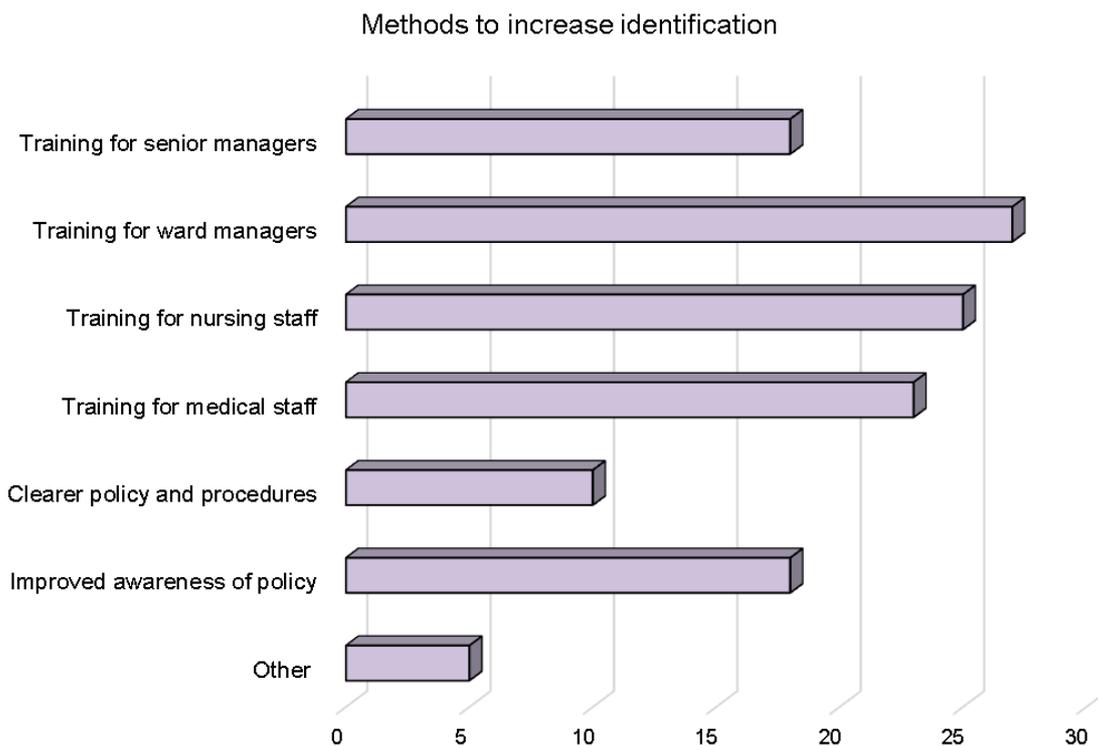
Of the 11 Trusts/Hospitals who said 'Yes':

- 4 had not submitted any applications (3 acute/community and 1 mental health/learning disability).
- The remaining 7 Trusts/Hospitals (5 acute/community and 2 mental health/learning disability) had submitted a total of 90 applications between them (respectively 10, 1, 18, 7, 9, 40 & 5). This was comprised of 61 Urgent Authorisations + Applications, 7 Standard Applications and 22 Repeat Applications.
- For only 1 of these 7 Trusts/Hospitals their rate of new/first time applications (total Urgent Authorisations + Applications and Standard Applications) was higher than the average for their type/size of Trust/Hospital.
- Overall therefore, 10 out of the 11 Trusts/Hospitals who answered 'Yes' had submitted fewer applications than the average amongst their peers.

### What would help increase the identification of DoLS?

(31 Trusts/Hospitals answered this question)

We asked participants to select from a pre-determined list (with the option to add 'other') what they thought would help in increasing the identification of potential DoLS.



The 5 Trusts/Hospitals who indicated 'other' identified: increased understanding of the Mental Capacity Act generally, MCA/DoLS Champions and clarification following 'Cheshire' due in 2013<sup>10</sup>.

<sup>10</sup> A case in the legal system in which the deprivation of liberty of an individual is disputed. In the Court of Appeal ([Cheshire West and Chester Council v P \[2011\] EWCA Civ 1257](#)) it was found that the case was not a DoL because of the 'purpose', 'aims', 'reasons' 'relative normality' and lack of alternatives in respect of the restrictions placed on P. The reasoning on which it was found that this was not a DoL has been questioned and clarity is expected when the case is presented before the Supreme Court later this year. In the interim, however, some indication of the way this case will be answered is provided by [Austin v UK 39692/09 \[2012\] ECHR 459](#), [CC v KK \[2012\] EWHC 2136](#) and [A PCT v LDV \[2013\] EWHC 272](#).

### Internal Processes – Questions for Consideration

- Have all staff who are permitted to complete DoLS Urgent Authorisations + Applications received specialist training?
- How are you assured that Urgent Authorisations and all Applications for Authorisation are being appropriately completed and all regulatory requirements are met, particularly where large numbers of staff are permitted or encouraged to complete these forms?
- Is the range of job roles staff able to complete the Urgent Authorisations and all Applications for Authorisation appropriate?
- Do staff completing the authorisation and application forms receive support and scrutiny to ensure authorisations and applications are appropriate and consistent?
- Is specialist knowledge available locally within divisions/specialties to provide support and scrutiny?
- Are further steps required to enhance the identification of potential deprivations of liberty, such as further training for clinical staff or having specialists available within each clinical directorate/ division?

## Findings – Applications Made

Any NHS Trust Hospital or Independent Hospital is classified as a ‘managing authority’ under the Deprivation of Liberty Safeguards. Managing authorities have responsibilities detailed within Schedule A1 of the Mental Capacity Act 2005, the associated regulations and the DoLS Code of Practice.

Paragraph 32 of Schedule A1 of the Mental Capacity Act states “(1) The managing authority of a hospital or care home must keep a written record of (a) each request that they make for a standard authorisation, and (b) the reasons for making each request”.

The Code of Practice states: “The complete process of assessing and authorising deprivation of liberty should be clearly recorded, and regularly monitored and audited, as part of an organisation’s governance structure. Management information should be recorded and retained, and used to measure the effectiveness of the deprivation of liberty processes. This information will also need to be shared with inspection bodies”.

The Health & Social Care Information Centre Guidance on the DoLS information returns<sup>11</sup> states: “The legislation includes a statutory requirement for all managing authorities as well as supervisory bodies to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person’s representative and the documentation related to termination of authorisation”.

However, 6 Trusts/Hospitals contacted us stating that they do not collate information about the number of DoLS applications made and the outcomes and therefore would not be completing the survey.

Whilst the 6 Trusts/Hospitals that contacted us suggested that the supervisory body would have this information and therefore they do not keep it, we consider that there is a significant risk to managing authorities if they do not collate this information themselves (we were asking for basic quantitative data about applications made). If managing authorities do not regularly assess their own application of the Safeguards they will be unable to identify weaknesses with their systems and processes and improve practice. We asked a couple of the Trusts/Hospitals whether they received regular reports from the supervisory body containing this information to which we received a negative response.

We are obviously unable to quantify how many more Trusts/Hospitals did not complete the survey because they did not have available the required information. This is something that would warrant further national scrutiny.

Given the findings in the previous section, it could be that some Trusts/Hospitals do not have the figures due to there being a large number of people completing and submitting the forms and therefore no central oversight, control or monitoring structure.

34 Trusts/Hospitals provided information about the number of applications. However, not all were able to provide information to all the subsequent questions about breakdown of figures,

---

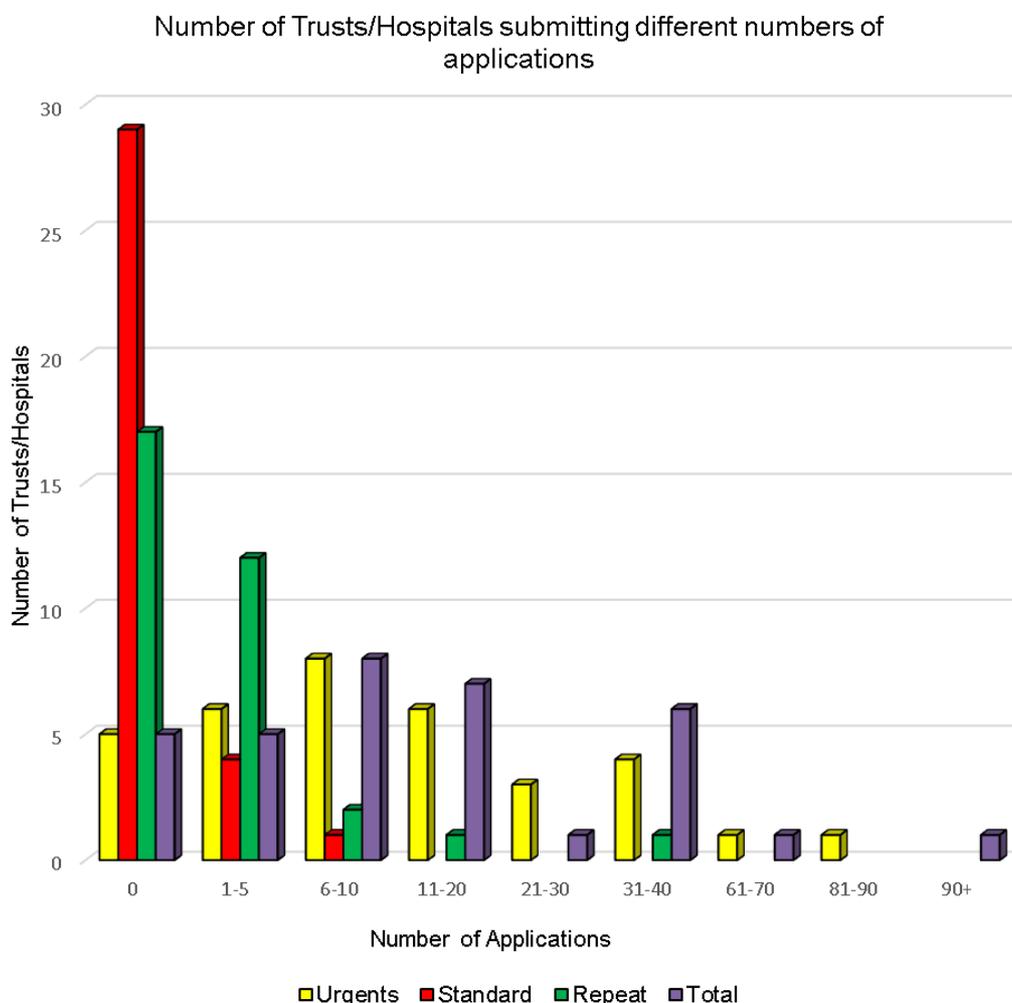
<sup>11</sup> Both current guidance published in 2011 and the provisional 2013/14 guidance (final guidance is due to be published at the end of March /beginning April 2013).

authorisation rates, reasons for non-authorisation and time periods of authorisations granted, leading to incomplete figures and several questions where the numbers provided were inconsistent and inaccurate. Potentially there is a significant number of Trusts/Hospitals which do not maintain methodical and robust systems for recording their DoLS activity and place too much reliance on supervisory bodies (PCTs) to record this information and monitor activity, despite the responsibilities directly placed on managing authorities.

### How many applications made?

*(34 Trusts/Hospitals answered this question)*

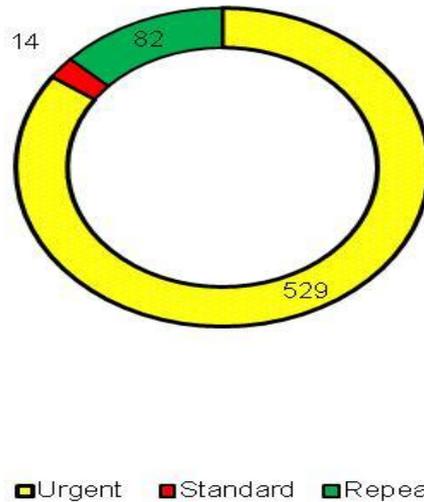
We asked how many applications were made in the 18 month period 1<sup>st</sup> April 2011 to 30<sup>th</sup> September 2012 of the different types: Urgent, Standard & Repeat.



29 out of the 34 Trusts/Hospitals had submitted at least 1 application (85%).

In total, the 29 Trusts had submitted: 529 Urgent Authorisations + Applications<sup>12</sup>, 14 Standard Applications and 82 Repeat Applications<sup>13</sup>.

Number of applications made by type



We compared the % in each age bracket, gender and disability type with the HSCIC data for 2011/2012 (where specific data in relation to PCT supervisory bodies is available we have used this. Otherwise figures are overall totals):

Age Bracket	HSCIC (Overall total)	Survey results
18-64	29%	42%
65-74	31%	19%
75-84	13%	25%
85+	29%	14%

The HSCIC figures include applications made in respect of people in care homes as well as hospitals and therefore it is maybe unsurprising that these survey results (examining just hospitals) show a larger % in the under 65 category and a lower % in the 85+ category.

<sup>12</sup> 1 Trust/Hospital was only able to supply 6 months data and 3 Trusts/Hospitals indicated that they had submitted Form 1 by itself (a total of 4 applications) which we included in the 'Urgent Authorisations + Applications' figures.

<sup>13</sup> 1 Trust/Hospital said they did not collect data on the number of repeat applications.

Gender	HSCIC (Overall total)	Survey results
M	47%	60%
F	53%	40%

The survey results suggest that a higher percentage of men are subject to applications in Trusts/Hospitals than in hospitals and care homes combined. This may be because care homes make up 72% of applications and given the differential in life expectancy between men and women, women comprise a larger percentage of residents in care homes. Additionally, in an acute hospital environment there is the possibility that staff may feel more challenged by males exhibiting challenging behaviour.

Form 4 requires the managing authority to classify the patient about whom the application is submitted into Physical Disability, Mental Health or Learning Disability. The wording of the form requests: “the disability that is causing their current incapacity”.

The classification into the 3 main ‘types of disability’ can seem at odds with the guidance around the MCA and the Safeguards themselves as:

- An individual cannot be said to lack mental capacity on the basis of a physical disability alone (for it to affect mental capacity the disability must impact on the functioning of their mind or brain. Otherwise Stage 1 of the 2-Stage test of capacity (diagnostic stage) will not be satisfied); and
- To be eligible for the Safeguards an individual must have a mental disorder (as defined in the Mental Health Act 1983 (as amended by the Mental Health Act 2007): “any disorder or disability of the mind or brain”) and it may be difficult to therefore distinguish between the mental disorder that all patients subject to applications must be suffering from and those where the ‘disability’ is ‘mental health’.

Similar to previous years, the proposed data collection for 2013/14 breaks the categories down into:

- Physical disability: Sensory impairment
- Physical disability: Other
- Mental health needs: Dementia
- Mental health needs: Other
- Learning disability
- None of the above (any other disability not listed)
- No disability

Trusts/Hospitals need to ensure that they are applying the classifications consistently across all of their DoLS applications (even where there may be differences between different agencies’ interpretation) to enable trends to be identified in the groups of patients that may require more targeted scrutiny of the restrictions being placed on them.

The table below shows that whilst the percentage of individuals identified as having a 'Physical Disability' is directly comparable between the HSCIC data in respect of PCT returns and our survey results, differences are apparent in the 'Mental Health' and 'Learning Disability' classifications.

Disability Type	HSCIC (Specific for PCT returns)	Survey results
Physical Disability	29%	27%
Mental Health	60%	52%
Learning Disability	11%	21%

## Breakdown of Urgent Authorisations + Applications

A total of 529 Urgent Authorisations + Applications were submitted by the 29 Trusts/Hospitals who had submitted any applications.

On the basis of the data provided from all 34 Trusts, we calculated the rate of applications per 100,000 inpatient bed days and the average ratio of applications to total number of inpatient beds (in the 18 month period)

Rate of apps per 100,000 inpatient bed days	Rate of apps per inpatient bed (over 18 months)
<b>8.3</b>	<b>1:39</b>

Although there was considerable variety in the number of applications made between Trusts/Hospitals (even controlling for inpatient bed days and number of inpatient beds), by combining all the data to establish an overall figure, this indicative rate becomes the best indicator available of a national rate in hospital settings. In **Appendices A & B** we have broken this down between Acute/Community Trusts/Hospitals and Mental Health/Learning Disability Trusts/Hospitals.

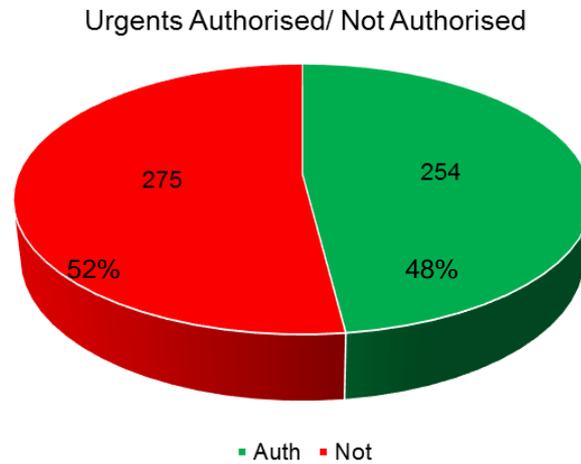
We asked for information on the breakdown of Urgent Authorisations + Applications by gender, disability and age bracket.

2 out of the 29 Trusts/Hospitals said they could not break down the number of applications between male/female. Also 5 Trusts/Hospitals' numbers were slightly out in that the breakdown they gave between male/female in the different age brackets did not quite match with their total overall number. Therefore the breakdown by male/female is provided for 423 Urgent Authorisations + Applications in total.

3 Trusts/Hospitals said they could not break down the figures by disability type (Mental Health, Learning Disability or Physical Disability) and 6 Trusts/Hospitals' figures did not correlate with their overall totals. Therefore the breakdown by disability is provided for 408 Urgent Authorisations + Applications in total.

Age Bracket	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	99	67	57	74	55	<b>39%</b>
65-74	59	29	12	49	20	<b>21%</b>
75-84	69	42	0	62	30	<b>26%</b>
85+	29	29	0	30	19	<b>14%</b>
<b>Total</b>	<b>256 (61%)</b>	<b>167 (39%)</b>	<b>69 (17%)</b>	<b>215 (53%)</b>	<b>124 (30%)</b>	

Despite 3 Trusts providing figures for the outcomes from Urgent Authorisations + Applications that did not tally with the figures for total Urgent Authorisations + Applications made, the total outcomes reported still equalled 529 and were split as follows:



### Breakdown of Standard Applications

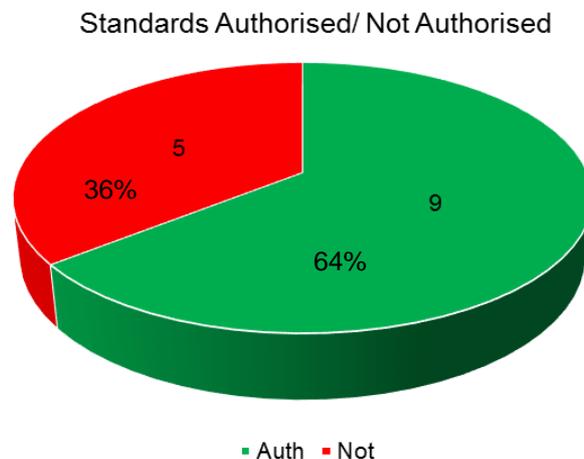
The total number of Standard Applications completed by participants was 14.

Rate of apps per 100,000 inpatient days	Rate of Apps per inpatient bed (over 18 months)
<b>0.22</b>	<b>1:1435</b>

5 Trusts/Hospitals (out of the 29 who had submitted any applications) submitted the 14 Standard Applications (1 Trust = 4, 1 Trust = 2, 2 Trusts = 1, 1 Trust = 6). Male/female and disability split were available for all 14.

Age Bracket	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	1	6	6	0	1	<b>50%</b>
65-74	1	0	0	1	0	<b>7%</b>
75-84	1	0	0	1	0	<b>7%</b>
85+	2	3	0	5	0	<b>36%</b>
<b>Total</b>	<b>5 (36%)</b>	<b>9 (64%)</b>	<b>6 (43%)</b>	<b>7 (50%)</b>	<b>1 (7%)</b>	

Of the 5 Trusts/Hospitals who had made Standard Applications, 2 Hospitals/Trusts provided figures in respect of outcomes that did not tally with the figures provided for the number of Standard Applications made, meaning a total of 18 outcomes were reported in respect of the 14 Standard Applications.



### Breakdown of Repeat Applications

The total number of Repeat Applications completed and recorded by participants was 82.

Rate of apps per 100,000 inpatient bed days	Rate of Apps per inpatient bed (over 18 months)
1.3	1:245

#### Repeat Application rate:

When considered against the total number of applications made: For every 6.6 Urgent Authorisations + Applications or Standard Applications, 1 Repeat Application was made.

When considered against the number of applications authorised: For every 3 new applications authorised, 1 Repeat Application was made.

For almost a third of authorised applications to be repeated might suggest that either the initial time periods for authorisations are overly cautious or that organisations are not doing all that is anticipated during the authorisation period to reduce the restrictions and therefore remove the deprivation, including considering whether hospital remains the most suitable environment in which to provide care, treatment and support.

Out of the 34 Trusts who answered the question about number of Repeat Applications made:

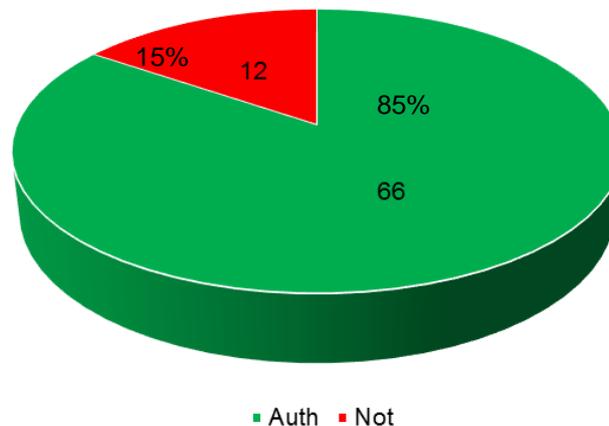
- 16 Trusts/Hospitals identified that they had made at least one Repeat Application;
- 1 Trust/Hospital stated that they did not record Repeat Applications made; and
- 17 Trusts/Hospitals identified that they had not made any Repeat Applications.

Of the 16 Trusts/Hospitals who had made at least one Repeat Application, 3 did not collect data broken down by gender or disability. The total Repeat Applications made for which split data is available is 73:

Age Bracket	Male	Female	LD	MH	Physical Disability	%
18-64	30	12	30	8	4	58%
65-74	7	1	0	7	1	11%
75-84	7	9	0	14	2	22%
85+	2	5	0	6	1	9%
<b>Total</b>	<b>46 (63%)</b>	<b>27 (37%)</b>	<b>30 (42%)</b>	<b>35 (47%)</b>	<b>8 (11%)</b>	

One Trust/Hospital did not record information about the outcome of Repeat Applications, making a total of 78 outcomes in respect of the 82 applications:

Repeats Authorised/ Not Authorised



It might be expected that Repeat Applications have a much higher authorisation rate than initial Urgent Applications, although it might be queried whether sufficient steps have been taken in the initial period of authorisation to reduce restrictions and therefore eliminate deprivation, including whether hospital remains the most suitable environment.

### Applications Made – Questions for Consideration

- How does your rate of applications per 100,000 inpatient bed days or number of inpatient beds compare to the indicative figures?
- Could any of your Urgent Authorisations + Applications have been predicted and therefore been Standard Applications, as should be the case wherever possible?
- Do you record information on all applications broken down by age, gender and disability type to enable review and benchmarking?
- Are you assured that the disability classifications are being applied consistently across the organisation?
- For applications that have been authorised, is a robust system of monitoring and scrutiny in place, in an attempt to ensure that restrictions are reduced and therefore Repeat Applications are minimised, including consideration of whether hospital remains the most appropriate environment in which to provide care and support to the individuals?

## Findings – Outcomes from Applications

### Overall Rate of Authorisation

*(29 Trusts/Hospitals answered this question)*

In total 9 Trusts/Hospitals provided outcome figures (number authorised/ number not authorised) that did not accord with the number of applications they stated had been made.

2 Trusts/Hospitals out of the 29 who had made applications did not have any applications authorised (one of which had submitted 1 application and one of which had submitted 10 applications).

1 Trust/Hospital out of the 29 who had made applications had all their applications authorised (did not have any non-authorised applications – only 1 application was made and authorised)

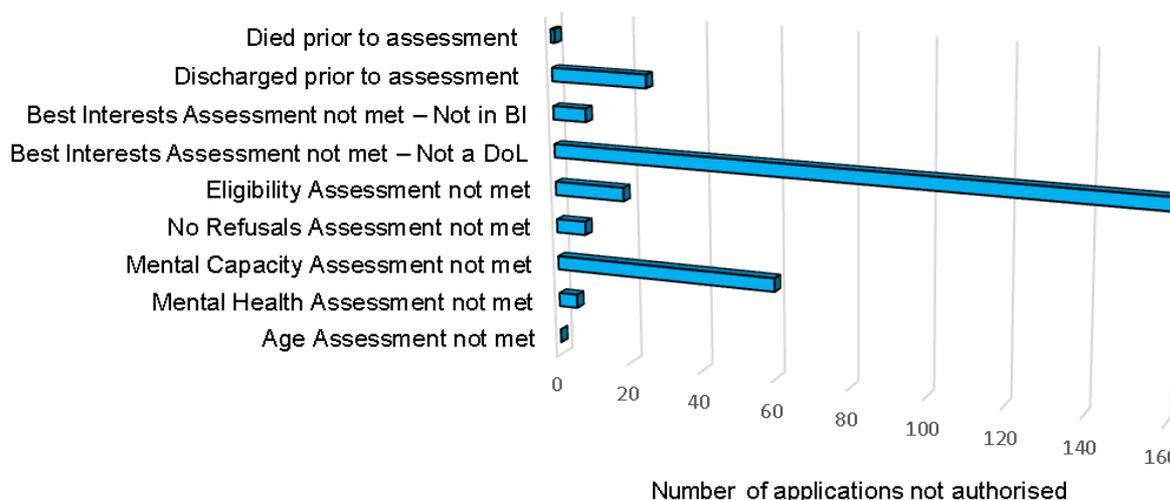
The HSCIC data states that the authorisation rate by PCTs (supervisory bodies for Trusts/Hospitals) is 52%. Overall in this survey, for the 625 applications for which outcomes were provided, the overall rate of authorisation was 53%. This indicates that the sample is representative in this regard.

### Reasons for Non-Authorisation

*(28 Trusts/Hospitals answered this question)*

In total the reasons for non-authorisation of applications were provided in respect of 288 non-authorised applications (out of the overall total of 292):

Reasons for Non-authorisation



‘Died’ and ‘discharged prior to assessment’ were not original options on the survey and it may be that others that might otherwise be captured in these categories have been included in the ‘Not a DoL’ option. 6 Trusts/Hospitals added the option of discharged prior to assessment, with one Trust/Hospital reporting that this happened in 16 out of the 42 applications not authorised.

The Code of Practice reiterates that applications are unlikely to be necessary for short admissions to hospital. The level of ‘discharged prior to assessment’ applications is therefore surprisingly high.

The table below shows the number of Trusts/Hospitals which had applications refused for each of the possible reasons:

Reason for Non-authorisation	Number of Trusts/ Hospitals with non-authorisations for this reason
Age Assessment not met	0
Mental Health Assessment not met	5
Mental Capacity Assessment not met	16 (at one Trust/Hospital this was the reason for all 19 non-authorisations)
No Refusals Assessment not met	1
Eligibility Assessment not met	8
Best Interests Assessment not met – Not a DoL	17
Best Interests Assessment not met – Not in BI	5
Discharged prior to assessment	6
Died prior to assessment	1

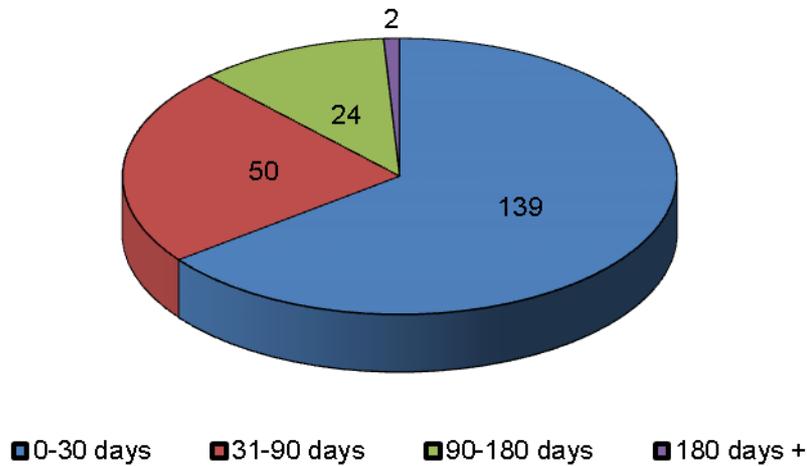
The fact that 16 different Trusts/Hospitals had applications refused because the patient did not lack capacity to consent to the arrangements made to enable care or treatment to be given might suggest that there are still some issues with assessing capacity. Although it could be argued that these patients may have fluctuating capacity, the question should then be raised as to whether they are suitable for the Safeguards.

### Period of Authorisation

*(23 Trusts/Hospitals answered this question)*

The data provided for the first question about initial time periods for new authorisations was in respect of 215 authorised applications (out of the 263 reported Urgent and Standard Application authorisations).

Number of new DoLS authorised for different time periods



Time period of Authorisation	HSCIC (Specific for PCT returns)	Survey results
0-90	77%	88%
91-180	10%	11%
181 - 365	9%	1%
366+	2%	

Despite 2 further Trusts/Hospitals not answering the further question about total time period of authorisation (1 stated they do not record the total period of authorisation) figures were provided for 219 authorisations (out of a total of 263 reported Urgent and Standard Applications authorised) (HSCIC data is not available for comparison).

Time period	Number of DoLS authorised for the time period in total (including repeats)	Number from Acute/Comm Hospitals (without MH or LD)	Number from Trusts/Hospitals with MH but no LD	Number from Trusts/Hospitals with MH + LD
0-30 days	112 (51%)	89	1	22
31-90 days	46 (21%)	30	6	10
90-180 days	38 (17%)	4	6	28
180 days +	23 (11%)	0	0	23

The average 'longest time period' for authorisation was 87 days and the average 'shortest time period' was 14 days.

Hospital admissions are generally expected to be for the shortest time possible to meet the acute needs of an individual requiring healthcare intervention that cannot be provided in the community. It is perhaps surprising, therefore, that 4 authorisations lasting between 90 and 180 days were in acute/community hospitals and a further 6 in Trusts/Hospitals providing mental health services but not specialist inpatient learning disability services. It is unclear how many of the 51 authorisations lasting longer than 90 days in Trusts/Hospitals with specialist mental health *and* learning disability services were for patients with a learning disability, although the figures for repeat authorisation applications from mental health and learning disability Trusts/Hospitals showed a more or less even split between 'mental health' and 'learning disability' as the disability leading to the application (see **Appendix B**).

Outside of specialist learning disability hospital 'units' it could be argued that authorisations lasting more than 90 days in a hospital environment are inappropriate and that more might be done to reduce and minimise restrictions on the patient to prevent deprivation of liberty occurring. Whilst all the deprivations of liberty identified by participants in this survey may genuinely represent the least restrictive method of providing care and treatment lengthy deprivations of liberty should necessitate increased scrutiny of the methods considered for reducing restrictions.

### Outcomes of Applications – Questions for Consideration

- What proportion of your applications were not authorised because the patient was discharged prior to the assessments taking place and therefore may not have been an appropriate application?
- Do you record the outcomes from all applications, including the reason for any applications not granted/refused and the total time period of granted authorisations?
- Do the reasons for non-authorisation inform your training plan for staff?
- How many of your authorisations last for more than 30 days? Are you assured that in respect of these authorisations all methods of reducing restriction have been considered and utilised?
- Have staff received training in the possible ways to reduce restrictions on patients and therefore avoid deprivations of liberty?



## Findings – Acute & Community

*(27 Trusts/Hospitals who deliver acute/community inpatient services provided sufficient data for classification as well as data about the number of applications made)*

For all the Trusts/Hospitals who provided 'ACS' services and/or had acute inpatient beds we identified the number of acute/community inpatient bed days and/or inpatient beds.

We included Trusts/Hospitals who also had designated mental health or learning disability beds where the acute/community inpatient activity outweighed the mental health and learning disability activity. We excluded one mental health & learning disability Trust/Hospital who also have inpatient community beds from the acute/community analysis, as the community inpatients were a small proportion of their overall service and therefore it was felt their results may distort the data (as it was likely the majority of their applications would have been for mental health/ LD patients).

We used the information provided about inpatient bed days, number of inpatient beds, WTE staff and income to judge the size of the Trusts/Hospitals into the following categories:

**Very Small** – Average 116 beds, Average 28,000 inpatient bed days per annum (therefore 42,000 over the 18 month period). 6 Trusts/Hospitals fell into this category.

**Small** – Average 450 beds, Average 145,000 inpatient days per annum (therefore 217,500 over the 18 month period). 7 Trusts/Hospitals fell into this category.

**Medium** – Average 700 beds, Average 230,000 inpatient days per annum (therefore 345,000 over the 18 month period). 11 Trusts/Hospitals fell into this category.

**Large** – Average 1057 beds, Average 318,000 inpatient bed days per annum (therefore 477,000 over the 18 month period). 1 Trust/Hospital fell into this category.

**Very Large** – Average 1675 beds, Average 542,000 inpatient bed days per annum (therefore 813,000 over the 18 month period). 3 Trusts/Hospitals fell into this category.

We then compared their level of acute/community activity against their number of applications and authorisations.

The tables that follow provide the same information tables and charts as in the main body of the report but purely for Acute/Community services and the applications made by them.

**Urgent Authorisations + Applications**

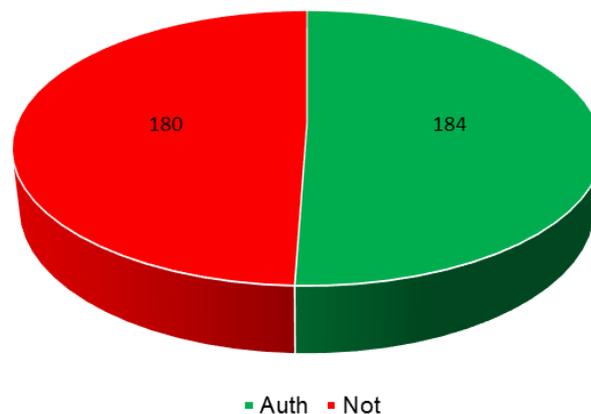
Trust/Hospital size	Ave number of apps per Trust/Hospital	Rate of apps per 100,000 inpatient bed days	Rate of apps per inpatient bed (over 18 months)
V small	1.4	3.3	1:83
Small	11	5.1	1:41
Medium	14.5	4.2	1:48
Large	6	1.3	1:176
V large	37.7	4.63	1:44
<b>Total</b>	<b>13.4</b>	<b>4.4</b>	<b>1:48</b>

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	56	31	7	55	49	34%
65-74	36	17	1	22	16	21%
75-84	51	27	0	32	26	30%
85+	19	19	0	13	16	15%
<b>Total</b>	<b>162 (63%)</b>	<b>94 (37%)</b>	<b>8 (3.4%)</b>	<b>122 (51.3%)</b>	<b>108 (45.3%)</b>	

(3 Trusts/Hospitals did not collect)

Outcomes were provided for 364 Urgent Authorisations + Applications (out of a total 363 Urgent Authorisations + Applications reported):

Urgents Authorised/ Not Authorised



**Standard Applications**

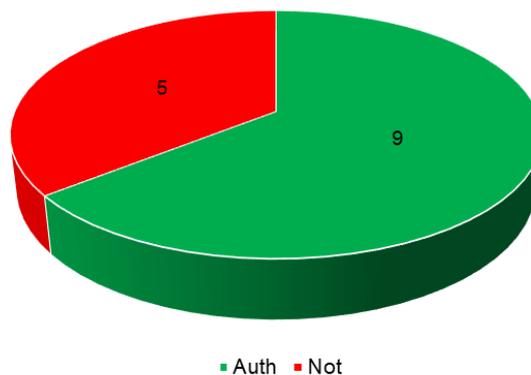
Trust/Hospital size	Ave number of apps per Trust/Hospital	Rate of apps per 100,000 inpatient bed days	Rate of apps per inpatient bed (over 18 months)
V small	1.2	2.9	1:97
Small	0	0	0
Medium	0.4	0.1	1:1925
Large	0	0	0
V large	0	0	0
<b>Total</b>	<b>0.4</b>	<b>0.1</b>	<b>1:1747</b>

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	0	3	2	0	1	30%
65-74	1	0	0	1	0	10%
75-84	1	0	0	1	0	10%
85+	2	3	0	5	0	50%
<b>Total</b>	<b>4 (40%)</b>	<b>6 (60%)</b>	<b>2 (20%)</b>	<b>7 (70%)</b>	<b>1 (10%)</b>	

(1 Trust/Hospital did not collect)

Outcomes were provided for 14 Standard Applications (out of a total 10 Standard Applications reported):

Standards Authorised/ Not Authorised



## Repeat Applications

Trust/Hospital size	Ave number of apps per Trust/Hospital	Rate of apps per 100,000 inpatient bed days	Rate of Apps per inpatient bed (over 18 months)
V small	1.2	2.9	1:97
Small	0.7	0.3	1:630
Medium	0.8	0.2	1:855
Large	1	0.2	1:1057
V large	2	0.24	1:828
<b>Total</b>	<b>1</b>	<b>0.3</b>	<b>1:647</b>

When considered against the total number of applications made: For every 13.8 Urgent or Standard applications, 1 Repeat Application was made.

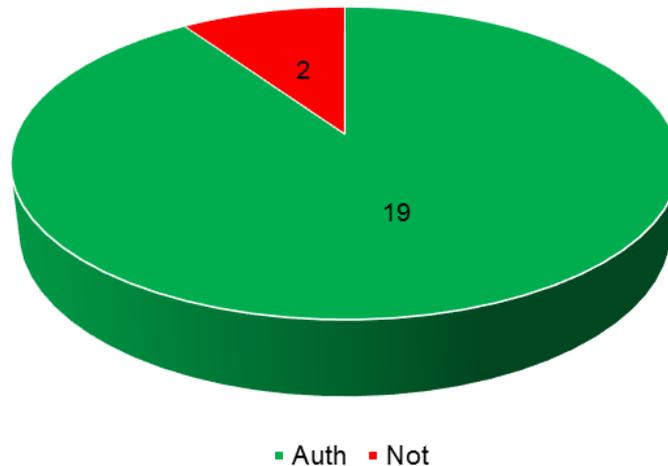
When considered against the number of applications authorised: For every 7.2 Urgent of Standards Applications authorised, 1 Repeat Application was made.

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	8	3	2	2	4	<b>50%</b>
65-74	3	0	0	0	1	<b>13%</b>
75-84	2	3	0	4	2	<b>24%</b>
85+	1	2	0	2	1	<b>13%</b>
<b>Total</b>	<b>14 (64%)</b>	<b>8 (36%)</b>	<b>2 (11%)</b>	<b>8 (44.5%)</b>	<b>8 (44.5%)</b>	

(3 Trust/Hospitals did not collect)

Outcomes were provided for 21 Repeat Applications (out of a total 27 Repeat Applications reported):

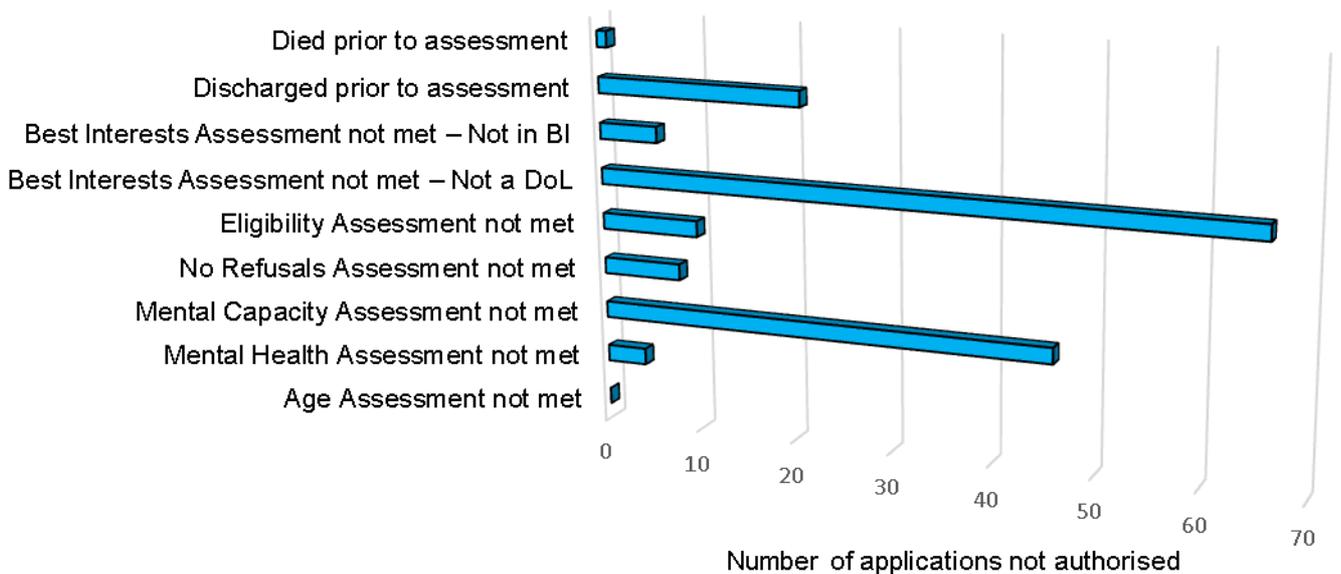
Repeats Authorised/ Not Authorised



**Reasons for Non-Authorisation**

The reasons for 162 of the non-authorisations were provided (out of the 187 non-authorisations reported).

Reasons for Non-authorisation



### Findings – Mental Health & Learning Disability

5 Trusts/Hospitals indicated that they had dedicated mental health beds. 5 Trusts/Hospitals indicated that they had dedicated learning disability beds. 4 of these Trust/Hospitals overlapped so there was a total of 6 Trusts/Hospitals identifying mental health and/or learning disability beds.

Due to the small numbers we have not separated these Trusts/Hospitals further and provide only overall figures.

1 Trust/Hospital had not made any applications

The tables that follow provide the same information tables and charts as in the main body of the report but purely for Mental Health/ Learning Disability services and the applications made by them.

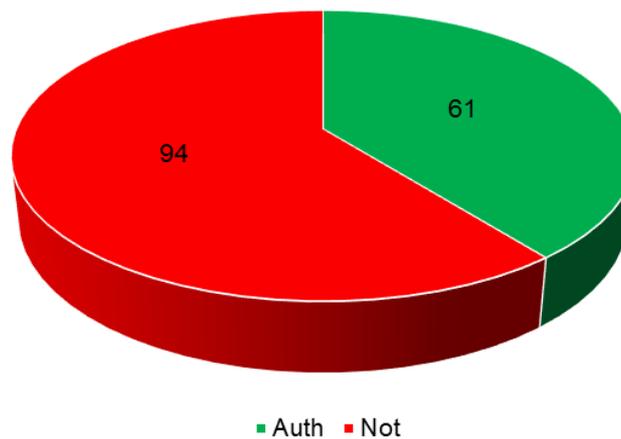
**Urgent Authorisations + Applications**

	Total number of apps	Ave number of apps per Trust/Hospital	Rate of apps per 100,000 inpatient bed days	Rate of apps per inpatient bed (over 18 months)
<b>Total</b>	<b>155</b>	<b>25.8</b>	<b>18.5</b>	<b>1:9</b>

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	39	30	50	18	1	45%
65-74	22	13	7	25	2	22%
75-84	17	15	0	29	3	21%
85+	9	10	0	16	3	12%
<b>Total</b>	<b>87 (56%)</b>	<b>68 (46%)</b>	<b>57 (37%)</b>	<b>88 (57%)</b>	<b>9 (6%)</b>	

Outcomes were provided for 155 Urgent Authorisations + Applications (out of 155 Urgent Applications reported):

Urgents Authorised/ Not Authorised



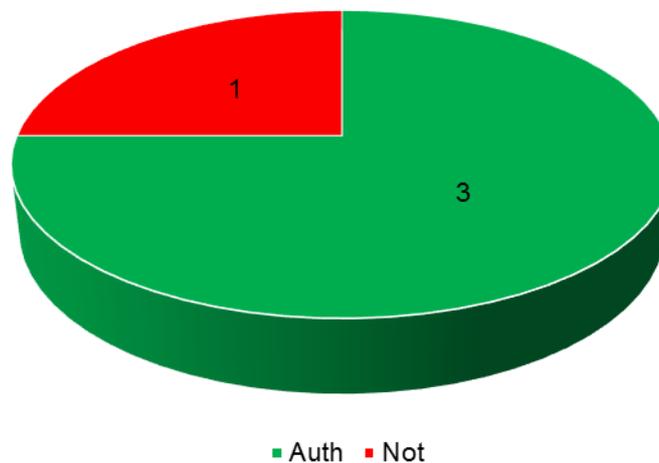
**Standard Applications**

	Total number of apps	Ave number of apps per Trust/Hospital	Rate of apps per 100,000 inpatient bed days	Rate of apps per inpatient bed (over 18 months)
<b>Total</b>	<b>4</b>	<b>0.7</b>	<b>843786</b>	<b>1:345</b>

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	1	3	4	0	0	100%
65-74	0	0	0	0	0	0
75-84	0	0	0	0	0	0
85+	0	0	0	0	0	0
<b>Total</b>	<b>1 (25%)</b>	<b>3 (75%)</b>	<b>4 (100%)</b>	<b>0</b>	<b>0</b>	

Outcomes were provided for 4 Standard Applications (out of 4 Standard Applications reported):

Standards Authorised/ Not Authorised



### Repeat Applications

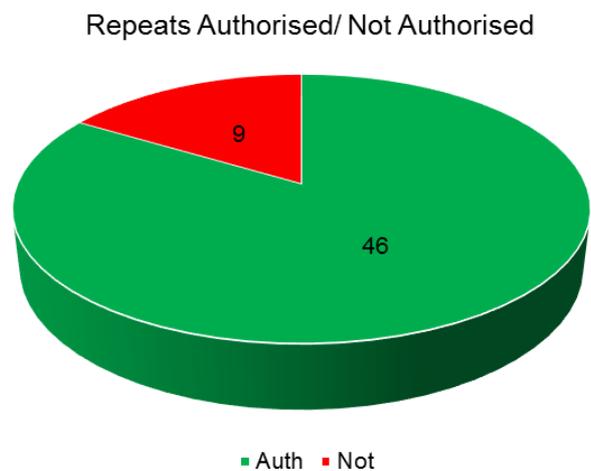
	Number of apps	Ave	Rate of apps per 100,000	Rate of apps per inpatient bed (over 18 months)
<b>Total</b>	<b>55</b>	<b>9</b>	<b>1</b>	<b>1:25</b>

When considered against the total number of applications made: For every 2.9 Urgent or Standard Applications 1 Repeat Application was made.

When considered against the number of applications authorised: For every 1.2 new Urgent or Standard Applications authorised 1 Repeat Application was made.

Age	Male	Female	LD	MH	Physical Disability	% in age bracket
18-64	25	9	28	6	0	62%
65-74	5	1	0	6	0	11%
75-84	5	6	0	11	0	20%
85+	1	3	0	4	0	7%
<b>Total</b>	<b>36 (65%)</b>	<b>19 (35%)</b>	<b>28 (51%)</b>	<b>27 (49%)</b>	<b>0</b>	

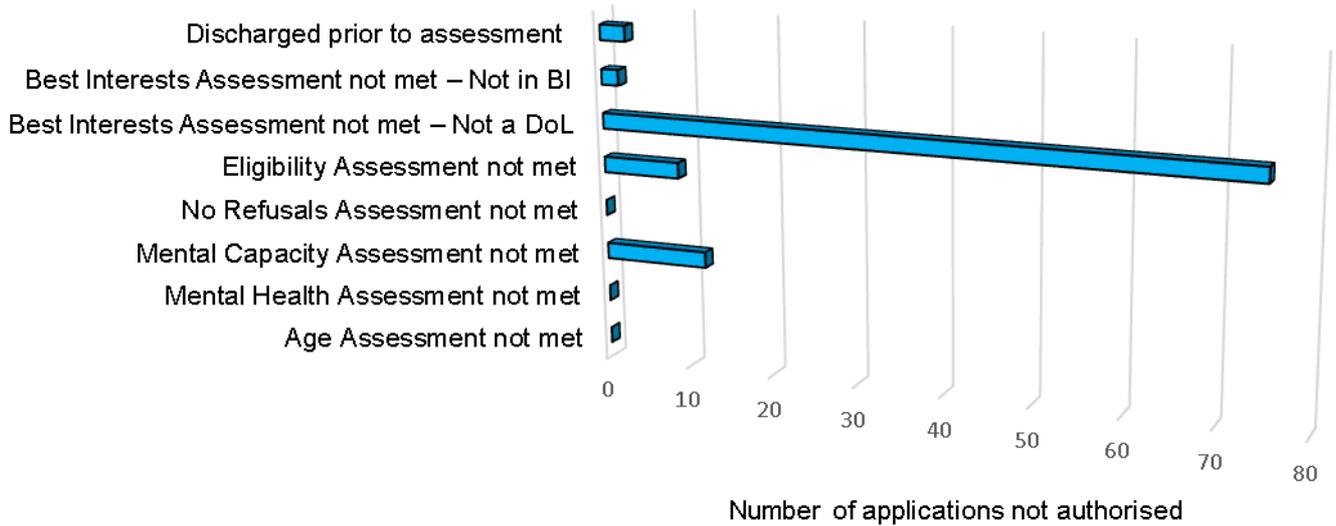
Outcomes were provided for 55 Repeat Applications (out of 55 Repeat Applications reported):



### Reasons for Non-Authorisation

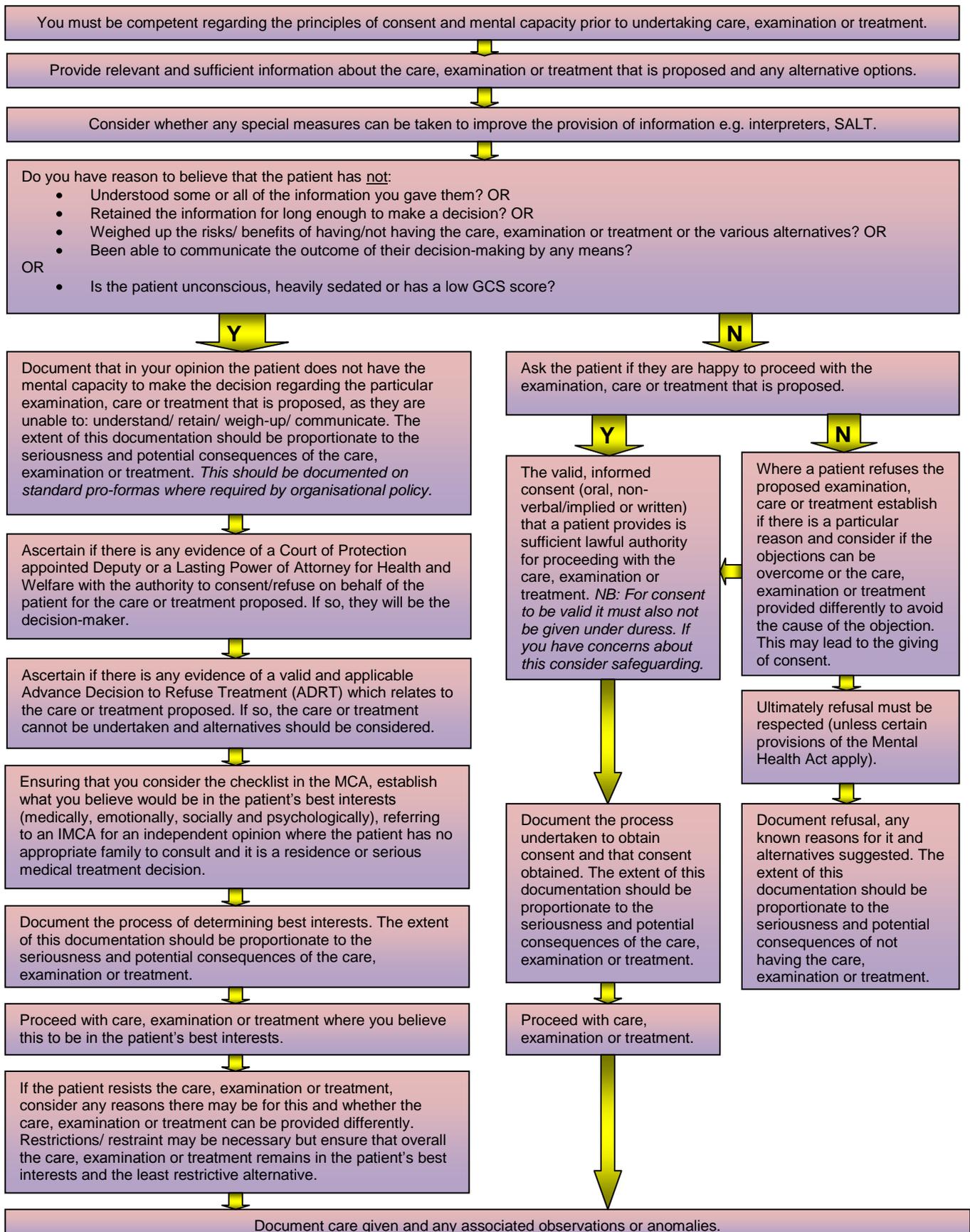
The reasons for 101 of the non-authorisations were provided (out of the 104 non-authorisations reported).

Reasons for Non-authorisation



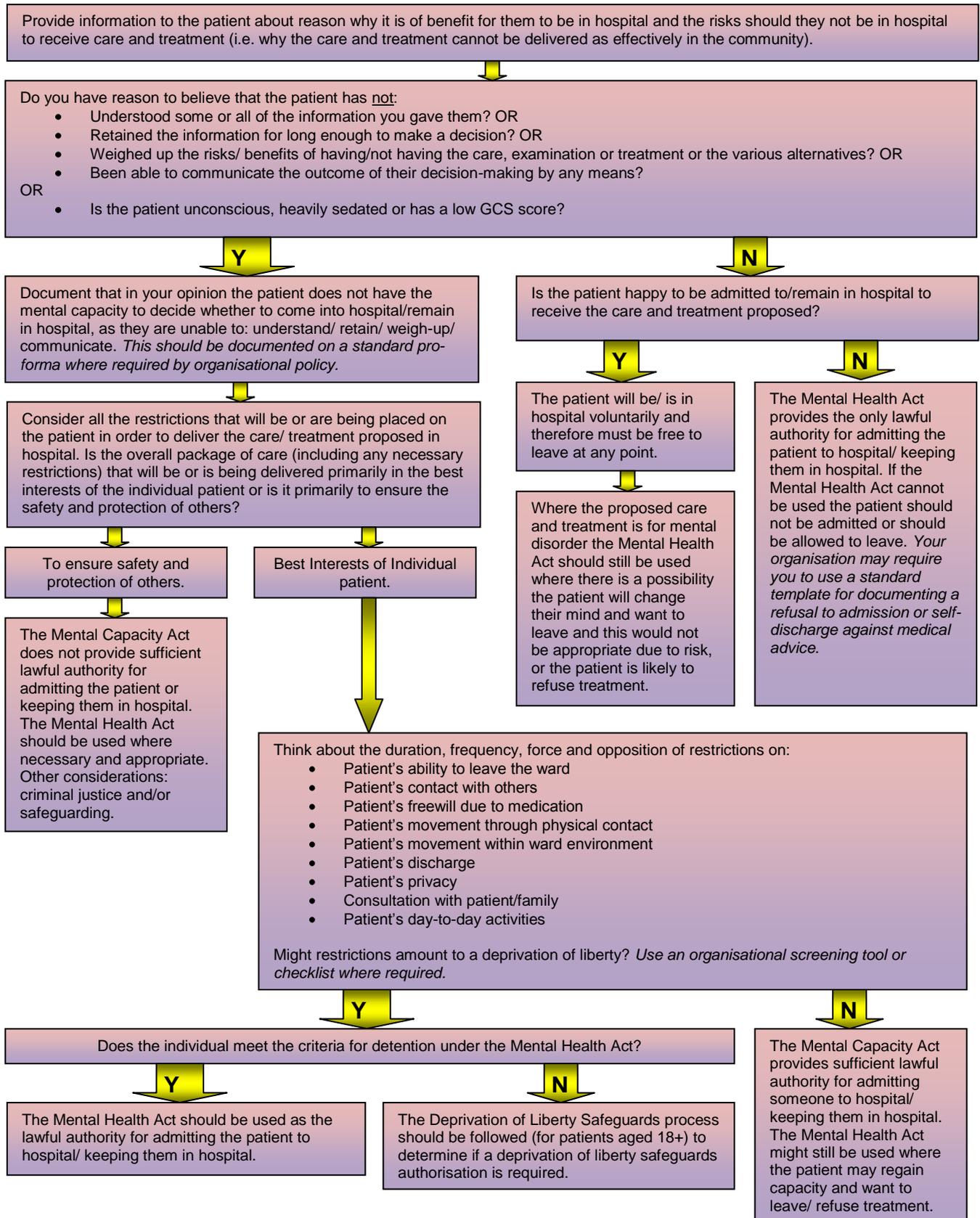
## Consent & Capacity: Meeting Legal and Regulatory Requirements

The steps outlined below will not necessarily occur in a linear fashion or in the order suggested. These steps are applicable to patients aged 16 and over. The steps to be taken for patients 15 and under are slightly different.



## Admission to Hospital/Preventing Someone from Leaving Hospital – Using the MCA, the MHA or the DoLS

The steps outlined below will not necessarily occur in a linear fashion or in the order suggested. This process applies only to patients who are 16 years or older as different arrangements are in place for under 16s.





Whilst this report is produced primarily for Trusts/Hospitals, we anticipate that it will be of interest and use to a variety of agencies. The report contains a considerable amount of data in the form of tables and charts, much of which we have not tried to draw conclusions from but present simply as information against which organisations can benchmark themselves.

Copies of the report and the Executive Summary are available on our website: [www.emias.nhs.uk](http://www.emias.nhs.uk).

**If you have any queries regarding the content of the report or would like to discuss your assurance mechanisms in relation to DoLs, please do not hesitate to contact Elaine Dower, Assurance and Development Specialist, emias on 07703 716968 or [elaine.dower@emias.nhs.uk](mailto:elaine.dower@emias.nhs.uk).**

Our thanks go to Browne Jacobson Solicitors for promoting involvement in the survey.

Thanks also go to Rachel Griffiths (Mental Capacity Act Development Manager for SCIE) for supporting the survey, providing sage words of advice and helping to shape the report.