The Third Year of the Independent Mental Capacity Advocacy (IMCA) Service 2009 / 10

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Description	The Mental Capacity Act created the Independent Mental Capacity Advocates (IMCAs) service and this is the third annual report of their activities. Over 9,000 people benefited from the support of IMCAs last year. This represents a 39% increase in referrals.
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The Third Year of the Independent Mental Capacity Advocacy (IMCA) Service 2009 /2010

Contents

Key points

- The range of decisions IMCAs are involved in was extended by the introduction of the Deprivation of Liberty Safeguards.
- Across England there was a 39.4% increase in the number of people supported and represented by an IMCA compared to last year.
- The IMCA service was supported by three initiatives on quality:

  -the advocacy qualification now available through City and Guilds;
  -the development of good practices guides by the Social Care Institute of Excellence and ADASS; and
  - the Quality Mark system developed by Action for Advocacy.

- There continues to be a wide variation in the number of IMCA instruction by local authority. This suggests that many vulnerable people without family or friends to represent them are may not be being referred to an IMCA for support for critical decisions which they lack capacity to make themselves.

Summary

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service as a safeguard for people without the capacity to make certain important decisions. The Act also introduced a legal duty on NHS bodies and local authorities to refer eligible people to the IMCA service. The IMCA service started on 1st April 2007 and this is the report on its third year's work (1st April 2009 – 31st March 2010).

The role of the IMCA is to represent and support people at times when critical decisions are being made about their health or care. They are mainly involved when the person lacks capacity to make these decisions themselves and they do not have family or friends who can represent them.

The Deprivation of Liberty Safeguards (DOLS) amended the Mental Capacity Act and were implemented on the 1st April 2009. They extended the IMCA role to support people who may be, or are being deprived of their liberty. This report includes information about the first year of these new DOLS IMCA roles.

Data about the IMCA service is collected by IMCA providers on a national database maintained by the Health and Social Care Information Centre. This report presents the information recorded on this database.

During the third year 9,173 people received representation from the IMCA service. This is a 39.4% increase from the previous year. Just under half of this increase (46.9%) is accounted for by the new DOLS IMCA roles.

Four thousand and eighty seven (4087) IMCA instructions were in relation to accommodation decisions – decisions about where a person should live. This is an increase of 16.9% over the last year. Six hundred and seventeen (617) were represented in care reviews; this is an increase of 59.4%. One thousand, three hundred and sixteen (1316) people were represented in decisions about serious medical treatment, which is a 36% increase. One thousand three hundred and twenty six (1326) people were represented in adult protection proceedings, which is a 38.1% increase. There were one thousand two hundred and fourteen (1214) IMCA instructions related to the Deprivation of Liberty Safeguards.

The Department of Health is pleased that there has been a continuing increase in instructions to the IMCA service in all areas. However there are still wide disparities in the rate of IMCA instructions across different local authorities which cannot wholly be explained by population differences. It is likely that some people are not referred to an IMCA, particularly when serious medical treatment decisions are being made.

The Mental Capacity Act Code of Practice states that local authorities and NHS trusts should have policies on when IMCAs should be instructed to represent people who are the focus of safeguarding adults' procedures and care reviews. Many local authorities have a policy on the involvement of IMCAs in safeguarding policy based on a model developed by ADASS and SCIE. There are however few policies covering care reviews. This includes many PCTs who do not have policies for the involvement of IMCAs in continuing NHS healthcare reviews.

The Department of Health has supported a number of initiatives relating to the quality of the IMCA service. This includes a qualification for IMCAs provided through City and Guilds; the development of good practice guides by Action for Advocacy, the Social Care Institute for Excellence and ADASS; and a quality mark initiative developed by Action for Advocacy.

Main report

The origin of the IMCA service

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service – and equally importantly - the legal duty to instruct the IMCA service in certain situations. The purpose of the IMCA service is to provide a safeguard to particularly vulnerable people who may lack the capacity to make critical decisions.
The duty to instruct the IMCA service applies to specific decisions in relation to people who lack capacity to make those decisions. The decisions identified in the original Act were: serious medical treatment and a move to, or a change in, long term accommodation. Regulations then introduced two further decisions where an IMCA service may be instructed: adult protection situations and care reviews. Apart from adult protection cases where this criteria does not apply, eligibility is targeted to those without the support of family and friends to assist in the decision making. IMCAs have been providing support to eligible people in all these areas since April 2007.

The Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 was amended by the Mental Health Act 2007. This added new provisions to the Act: the deprivation of liberty safeguards. The safeguards focus on some of the most vulnerable people in our society: those who for their own safety and in their best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack the capacity to consent to the regime.
The Deprivation of Liberty Safeguards (DOLS) extended the IMCA role to supporting and representing people who may be either lawfully or unlawfully being deprived of their liberty.
The Department of Health supported the training of IMCAs in preparation for this extension to their role. This training was developed by Advocacy Partners and delivered by Action for Advocacy.

There are three distinct IMCA roles in the Deprivation of Liberty Safeguards. These are referred to by the Sections in the amended Mental Capacity Act where they are described.

Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.

Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.

Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

These roles have distinct powers and responsibilities. Collectively in the report they are referred to as the DOLS IMCA roles.

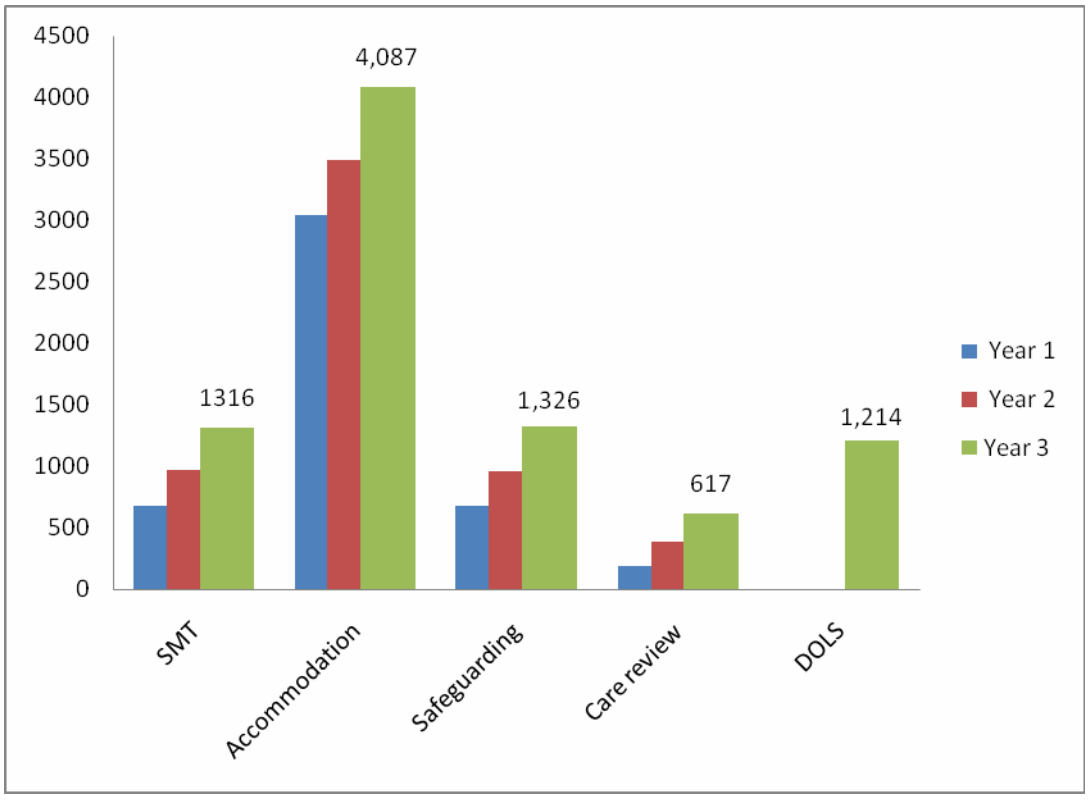
The source of the data

Since the IMCA service began in April 2007 IMCA providers have been recording details about each case on a national database maintained by the Health and Social Care Information Centre. This report provides information about recorded IMCA referrals which were made on or between the 1st April 2009 and the 31st March 2010.
The database records data for England and Wales. This report only includes the data for England.

Number of eligible IMCA instructions

There were 9173 eligible IMCA instructions during year 3. This represents an increase of 39.4% on year 2. Table 1 shows the eligible instructions for the first three years by reason for IMCA instruction. The numbers for year 3 are identified. The type of eligible instruction was unrecorded in 613 cases.

Table 1 Eligible IMCA instructions



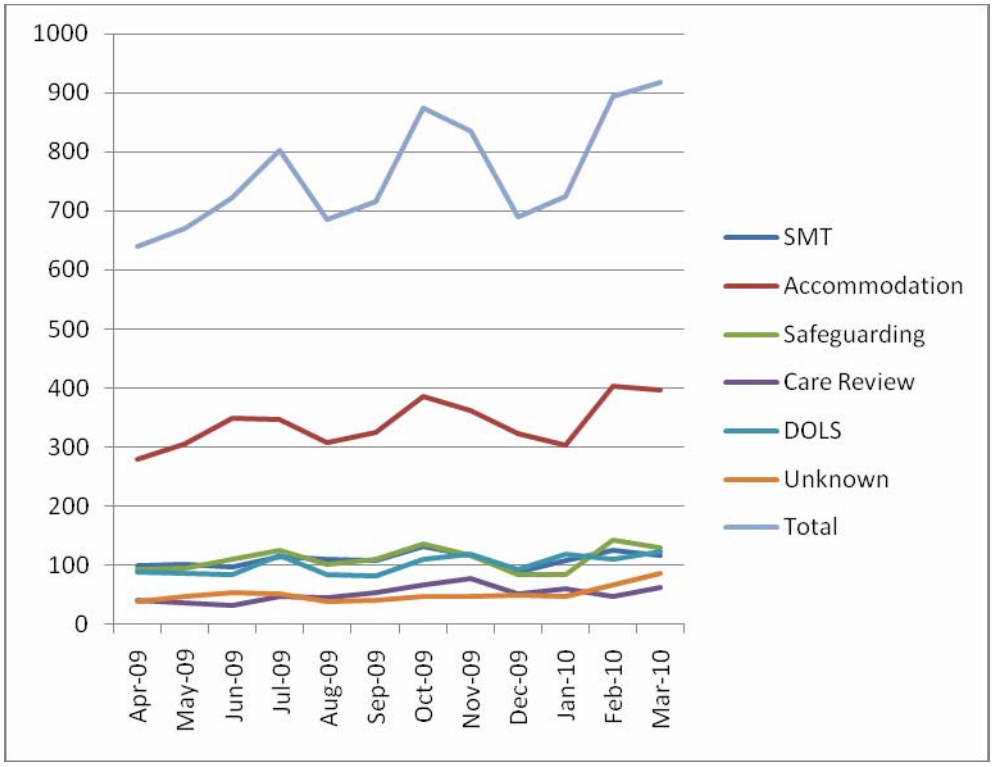
The table shows that each year there have been increases in all areas of IMCA instructions.

Accommodation decisions continue to dominate the work of IMCAs making up 44.5% of all eligible instructions in year 3. The number of DOLS instructions in the third year (1,214) is similar to that of serious medical treatment (SMT) and safeguarding adults instructions.

Table 2 shows the numbers of instructions for each of the last 12 months. There are two clear dips in the rate of instructions. These are around the months of August and December/January. This may be a refection of holiday patterns in local authorities and NHS trusts affecting levels of activity.

The level of DOLS instructions was consistent throughout the year. This suggests a consistent understanding by many supervisory bodies of the IMCA roles in DOLS when the safeguards were first implemented in April 2009.

Table 2 Eligible instructions by month



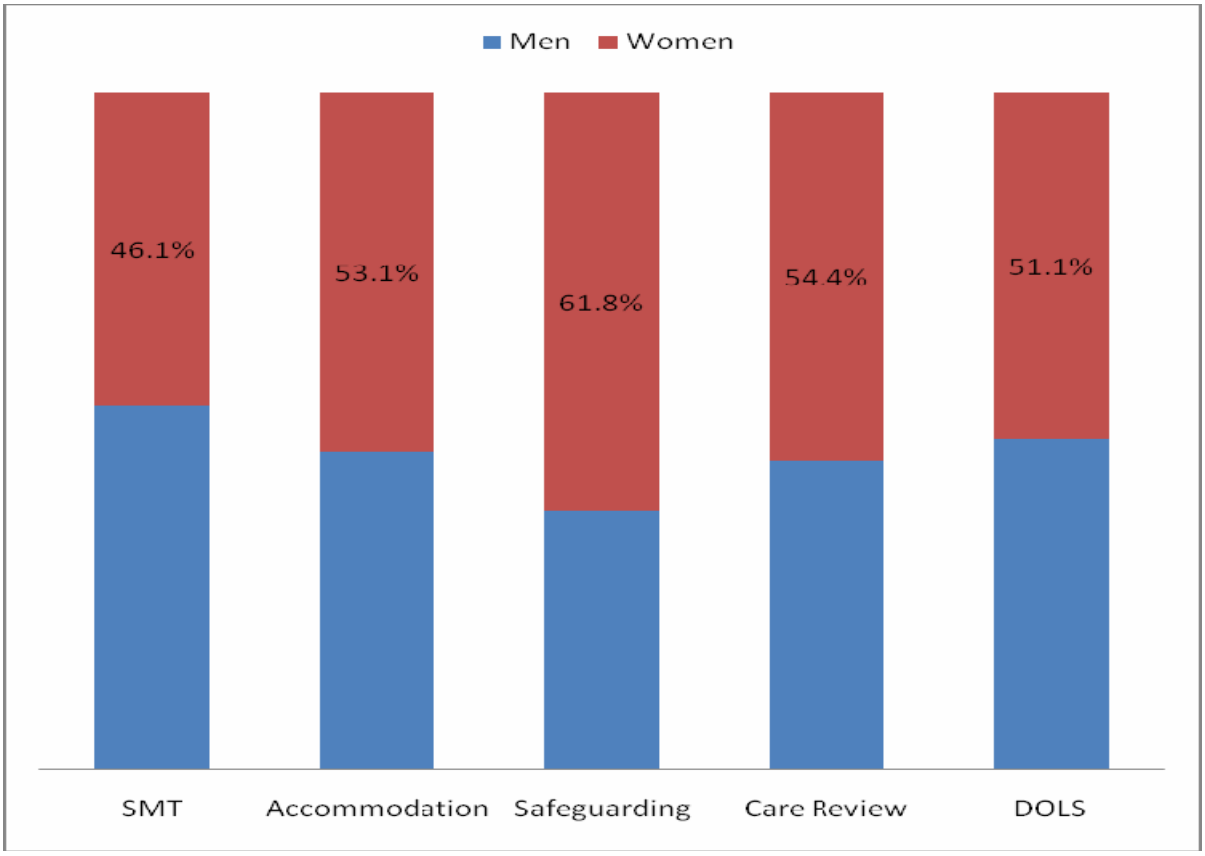
Who benefits from the IMCA service

Just over half (53.4%) of people receiving the IMCA service were women in year 3 which is consistent with the two previous years (year 1: 53.5%, year 2: 53.4%). This is slightly higher than the percentage of women in the adult population in England which currently stands at 51.2%1. This variation can be partly explained by the age profile of people receiving the IMCA service. Table 3 shows the gender breakdown by reason for instruction where known. It reveals two significant variations in gender. The first being the relatively high proportion of

[1] Mid -2009 Population Estimates England, Office for National Statistics

women represented for safeguarding issues (61.8%) and the relatively low proportion of women represented for serious medical treatment decisions (46.1%).

Table 3 Gender



The age profile of people instructed to the IMCA service has been consistent for the first three years. For example, people aged 80 and above have always represented about a third of all instructions (year 1: 33.5%, year 2: 33.5%, year 3: 34.0%). Similarly people between the ages of 66 and 79 represent about a quarter of all instructions (year 1: 24.3%, year 2: 24.1%, year 3: 25.7%).

Table 4 shows the age of people instructed by reason of instruction where known. The instructions for people under the age of 18 are not shown because these are so low (8 accommodation and 1 safeguarding instructions).

There are some clear age variations in the reasons for instructions. The age profile for serious medical treatment decisions stands out as being significantly different. For example, people 80 and over make up only 17.3% of serious medical treatment instructions compared to 36.8% of all other eligible instructions. Whilst those people between the ages of 46 and 65 make up 40.3% of serious medical treatment instructions compared to 20.9% of all other eligible

instructions. This pattern is found in the previous year's data and does raise questions about why there is this variation in gender in instructions to the IMCA service.

Table 4 Age profile by reason for instruction

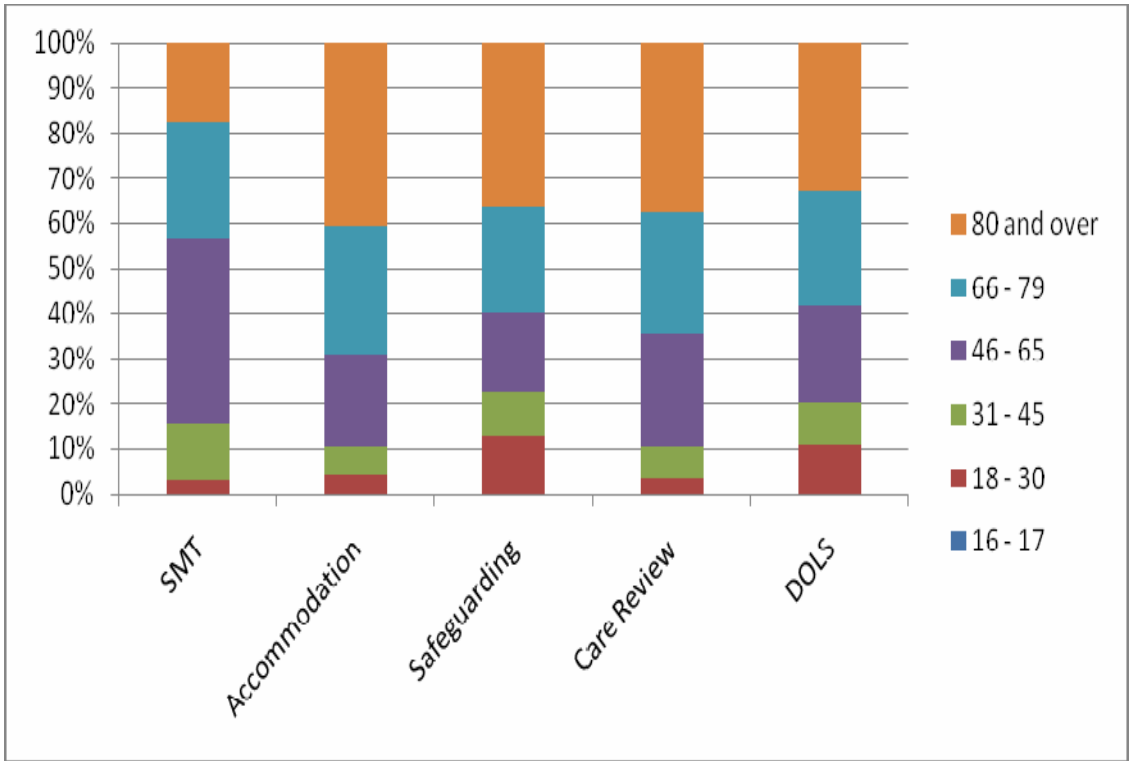


Table 5 shows the ethnicity of the people instructed where known. This is broadly in line with the population of England. Because of the majority of people who receive the service are 66 or over, a comparison for the number of men over 65 and women over 60 is given[2].

[2] Source **Current Estimates - Population Estimates by Ethnic Group Mid-2007 (experimental)**, Office of National Statistics.

Table 5 Ethnicity of people receiving the IMCA service

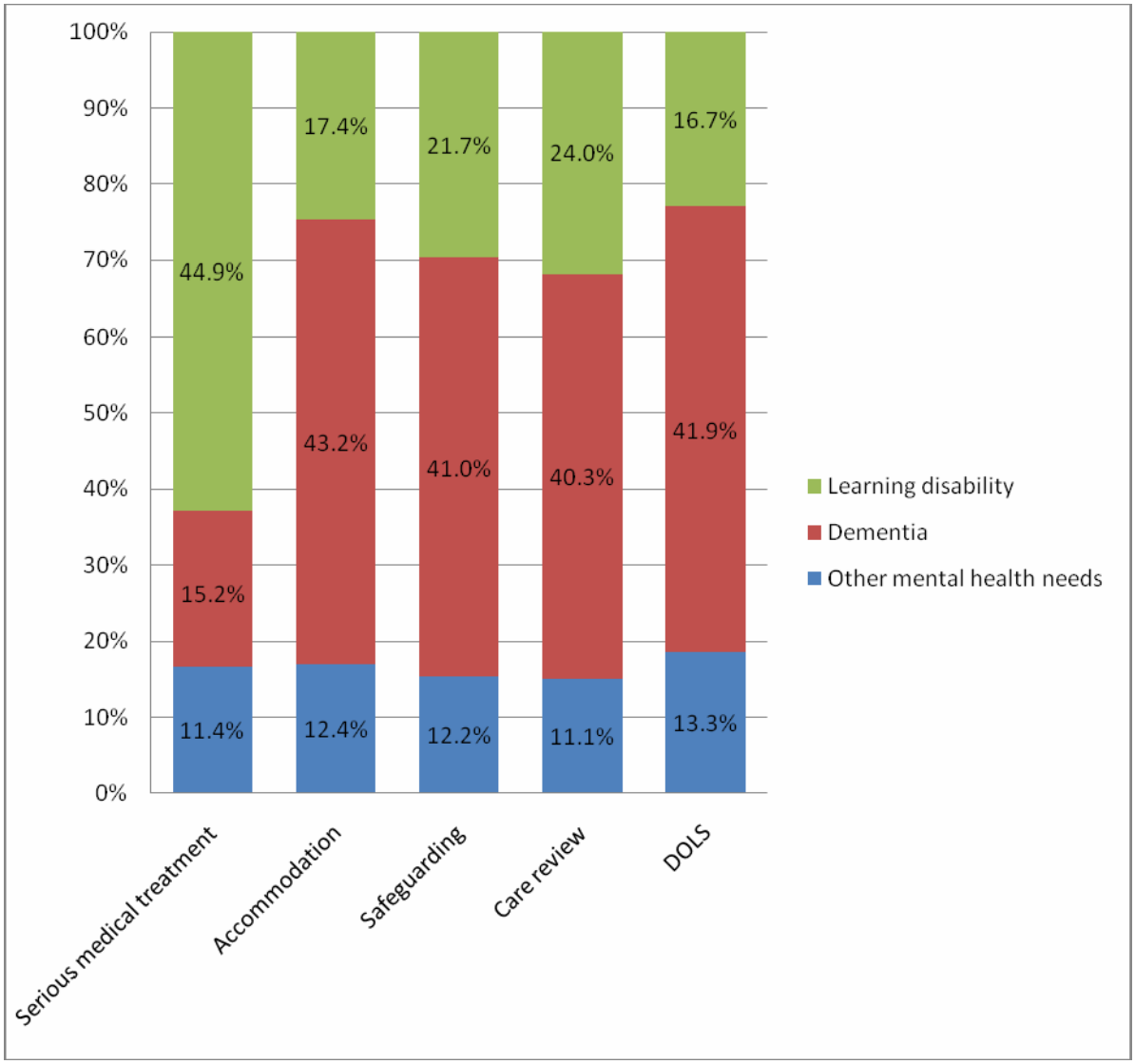
Ethnic group	IMCA instructions (n)	IMCA instructions (%)	England population all ages (%)	England: men 65+ women 60+ (%)
White	8238	92.7%	90.9%	95.9%
Asian or Asian British	253	2.8%	4.6%	2.2%
Black or Black British	254	2.9%	2.3%	1.3%
Mixed	82	0.9%	1.3%	0.3%
Chinese, including British Chinese	14	0.2%	0.4%	0.2%
Other	41	0.5%	0.4%	0.2%

Why people may lack capacity to make decisions

The first stage of the mental capacity assessment is to identify if a person has an impairment of the function of the brain. The most common impairments for people receiving the IMCA service in year 3 were dementia (37.6%), learning disabilities (23.3%) and mental health problems other than dementia (12.3%). These are very similar to the figures for year 2 (35.3 %, 20.4% & 13.7% respectively). The other known impairments recorded for year 3 were: cognitive impairment (8.1%), acquired brain damage (4.4%), serious physical illness (3.6%), autistic spectrum disorder (2.3%) and unconsciousness (0.4%). The impairment was unknown is 8% of cases.

Table 6 shows the percentage of the three most common impairments for the different types of instructions where both are known. The proportions for serious medical treatments are significantly different to all other instructions. The relatively low proportion of people with dementia who received the support of an IMCA for a serious medical treatment decision (15.2%) reflects the relatively low number of people over 80 identified above who receive this service. It is also significant the high proportion of people with learning disabilities who are supported by IMCAs for serious medical treatment decisions (44.9%).

Table 6 Impairment and type of instruction



Where were people when the IMCA was instructed?

Table 7 shows where the person was staying at the time of the IMCA instruction where this was recorded. (This table does not include two eligible instructions for people while they were in prison. For both the IMCA was instructed to support and represent them for the decision about where they should live after they were released.)

The majority of people were staying in a regulated service when the IMCA was instructed. This is broken down as 44.8% in care homes and 38.1% in hospital. 11.5% of people were living in their own home and a further 5.5% in some form of supported living.

Table 7 Where the person was at the time of instruction

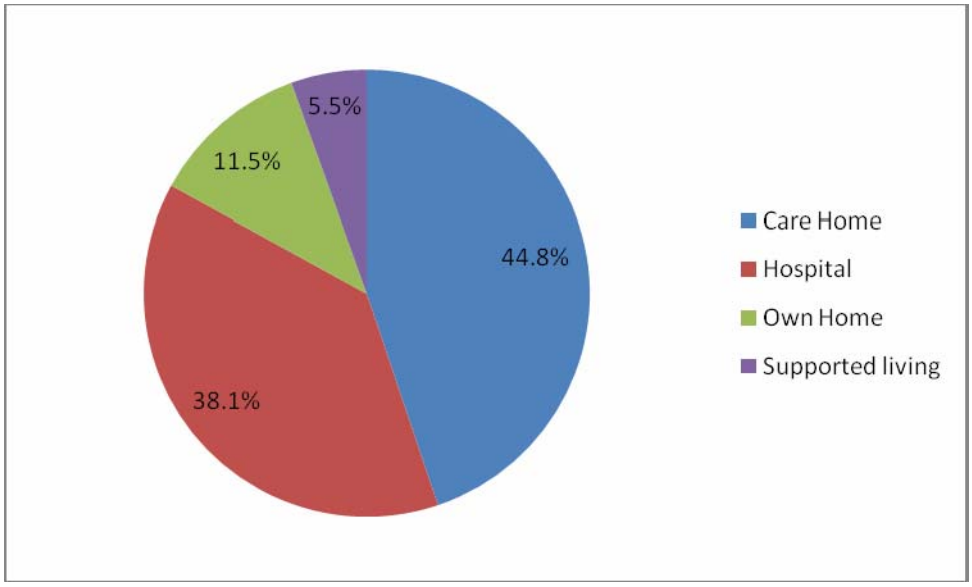
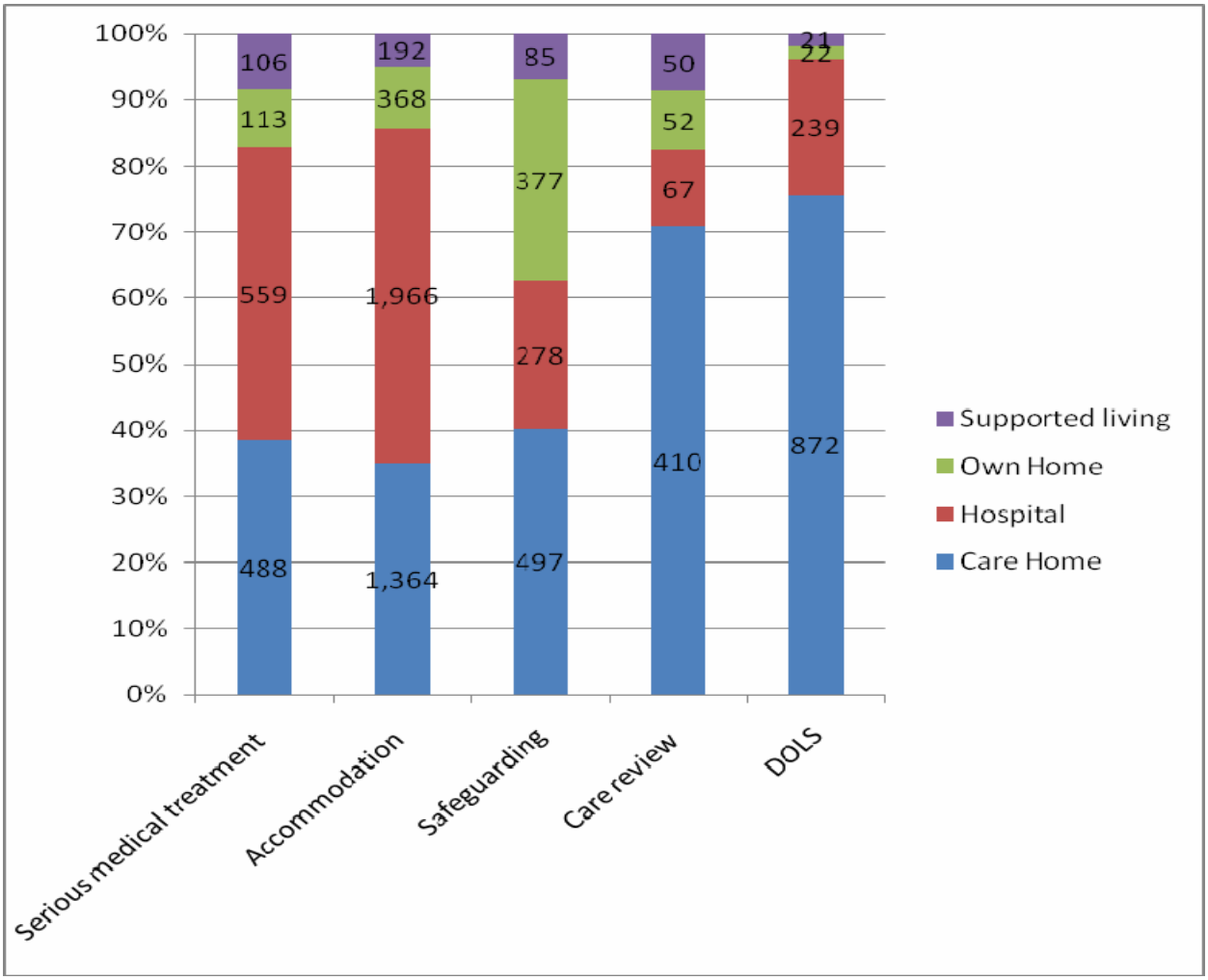


Table 8 examines where people were staying at time of instruction compared to the reason for instruction where both are known (again excluding the two people in prison).

Of note are the relatively high levels of instructions in relation to safeguarding adults for people living in their own home and the relatively small number for people staying in hospital. It is not surprising that so few people were instructed in relation to DOLS were outside of a hospital or care home. This is because the DOLS can only be used to deprive someone of their liberty in a hospital or care home.

Table 8 Where the person was and differing instructions



What were the serious medical treatment decisions?

There is a duty to instruct IMCA when a serious medical treatment decision needs to be made in the best interests of someone lacking capacity to make that decision, who does not have anyone appropriate to consult.

Table 9 records the range and number of medical decisions where people received the support of an IMCA. The most common decisions relate to medical investigations (17.6%), dental work (12.7%), whether resuscitation should be attempted (12.5%) and cancer treatment (7.5%). These were also the most frequent SMT decisions in year 2 (16.9%, 10.6 &, 10.6% and 8.9% respectively).

Table 9 Serious medical treatment decisions

Decision	n=1316	Percentage
Medical investigations	232	17.6%
Dental work	167	12.7%
Do not attempt to resuscitate	165	12.5%
Cancer Treatment	97	7.4%
Affecting hearing or sight	38	2.9%
Major Surgery	36	2.7%
Artificial nutrition or hydration	32	2.4%
Hip or leg operation	27	2.1%
Major amputation	16	1.2%
ECT	6	0.5%
Pregnancy termination	4	0.3%
Other	496	37.7%

There were six instructions in relation to whether ECT should be given. This was the period in which additional safeguards were introduce by the Mental Health Act for ECT being given to people detained in hospital who lack capacity to consent to treatment, and for those people under 18.

The four IMCA instructions in relation to potential pregnancy termination are also interesting. The code of practice expects in certain cases for these decisions to be made by the Court of Protection (6.19).

IMCAs have a right to request a second medical opinion in relation to the treatment decision. This right was exercised in 91cases (6.9% of SMT decisions) and led to second medical

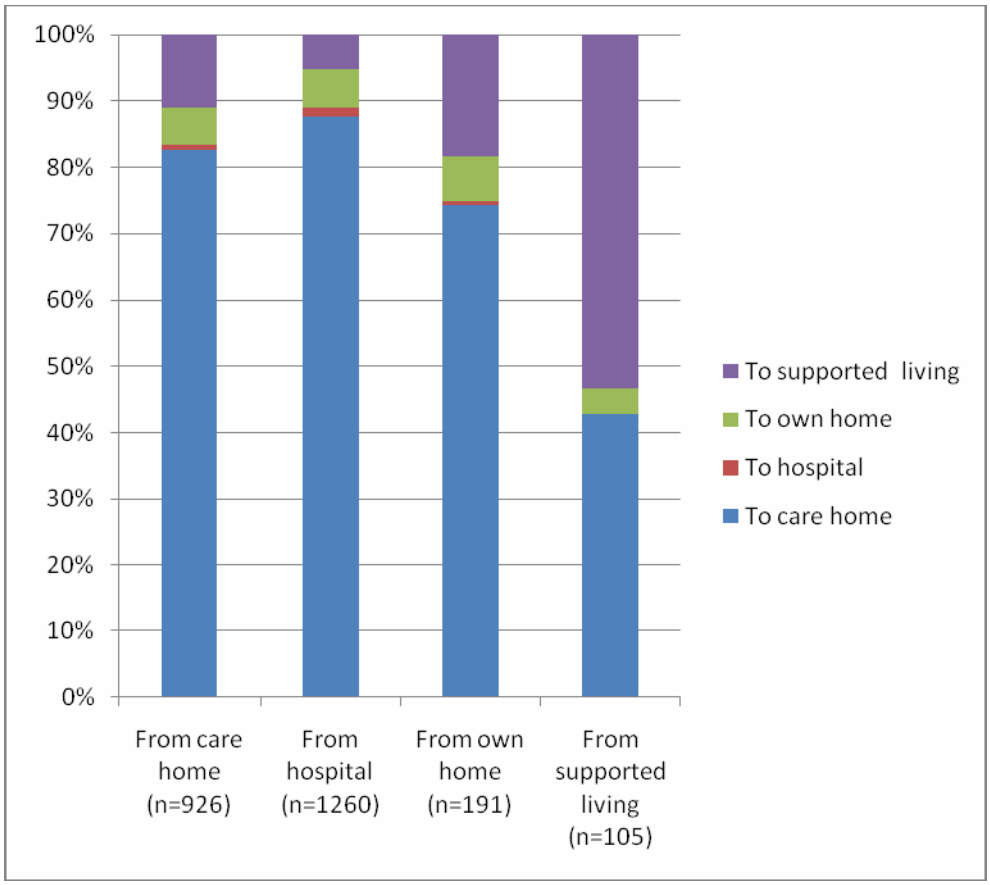
opinions being provided in 82 (90.1%) cases where requested). It is not clear the reasons why a second medical opinion was obtained in the other 9 cases.

What were the outcomes of the accommodation decisions?

Table 9 above showed where the person was staying at the time an IMCA was instructed where known. Just over half of the accommodation decisions were where a person should be discharged to after a stay in hospital (50.5%). The other accommodation decisions involved people initially living in care homes (35%), their own home (9.5%) or some form of supported living (4.9%). There were also two accommodation decisions for people in prison.

Table 10 compares where the person was staying when the IMCA with instructed with the outcome of the accommodation decision where known.

Table 10 Outcomes of accommodation decisions



Where a person is shown to stay in the same type of accommodation they may still have moved. For example, from one care home to another.

The lack of a clear distinction between own home and supported living makes some of these results difficult to interpret. For example, if someone is living in their own home and the

outcome of the accommodation decision is to provide a package of support to allow them to continue to live there it is not clear whether the IMCA will have recorded the outcome as own home or supported living.

The outcome of the majority of all accommodation decisions where known is for the person to live in a care home (82.9%). People staying in hospital were the most likely to move to a care home (87.6%). Only 6.8% of people are recorded as staying in their own home. However the figures is likely to be higher as some of the people where the outcome is recorded as supported living may have received a package of support to allow them to continue living in their own home.

IMCAs may have had an impact on the type of accommodation but also the choice or accommodation. For example, whether the specific care home best meets the person's needs and wishes? IMCA may also have an impact on the support the person receives in the care home. This can happen by the IMCA providing information to the care home provider about the person's history, needs and wishes.

Planned stays in hospital accounted for at most 1% of accommodation decisions. IMCAs must be instructed for non emergency admissions where the stay in hospital is likely to be 28 days or longer. The Code of Practice expects IMCAs to be instructed by NHS bodies as soon as they realise that a stay in hospital may exceed 28 days (10.55).

In over a third of closed cases the outcome of the accommodation decision is not recorded. This is in part because a number of people will have died before a potential move.

Deprivation of Liberty Safeguards

As noted above the IMCA roles were extended in year three to represent people in relation to the Deprivation of Liberty Safeguards. The three new roles are:

Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.

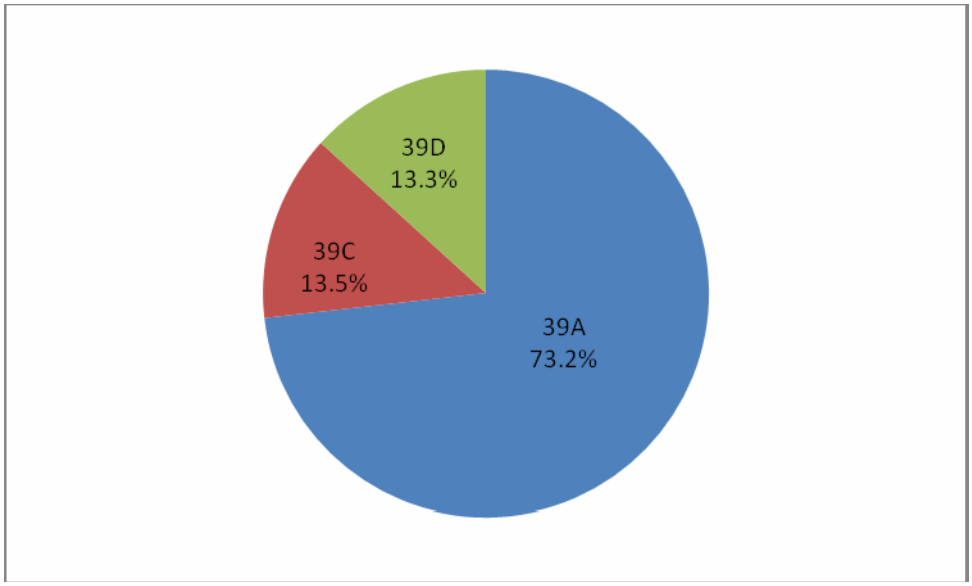
Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.

Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

Table 11 shows the breakdown of the 1,214 DOLS instructions where this is known. It shows that about three quarters of instructions were to support and represent people who were being assessed as to whether they are being, or need to be deprived of their liberty (the section 39A role).

There were a total of 7157 requests for standard authorisation during this year[3]. The 872 section 39A instructions equates to 12.2% of people being represented by an IMCA in the assessment process for a standard authorisation. The outcome of the assessment process when a 39A IMCA was instructed is not recorded in a high number of cases (23.7%). Where the outcome is known 60.9% of requests led to a standard authorisation being granted. This is higher than the rate for all requests across England which was 46.1%[4.] It will be useful to review the data for the fourth year to see if there is a pattern of those people being represented by a 39A being more likely to have a standard authorisation granted.

Table 11 Breakdown of IMCA DOLS instructions

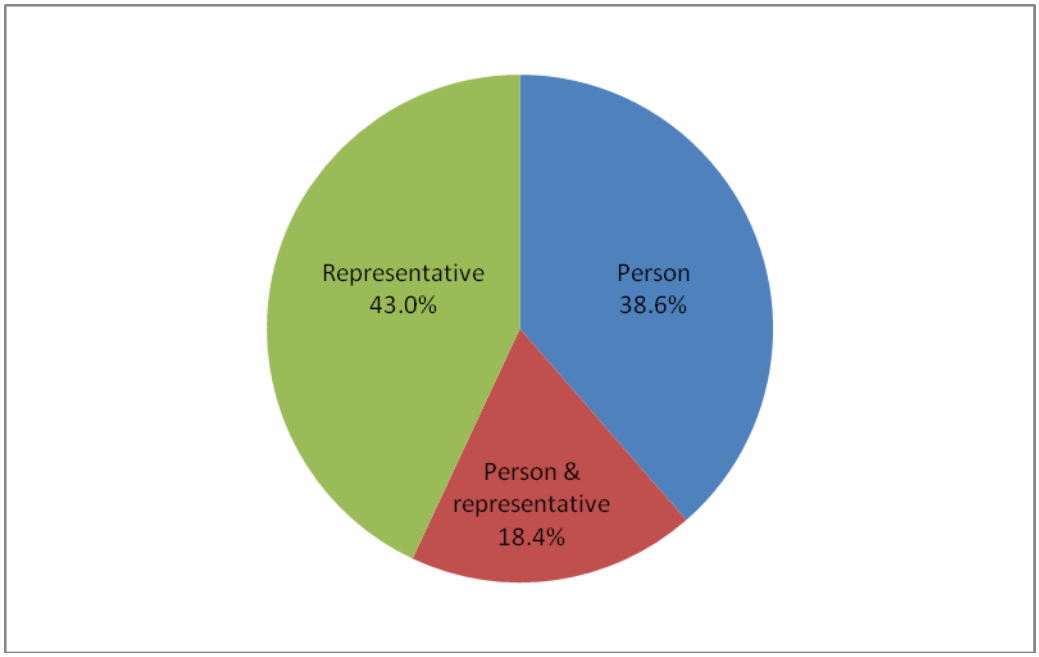


The proportion of 39C instructions is surprisingly high at 13.5%. The legislation sets out this role to cover gaps in the availability of a relevant person's representative. Specifically it requires the appointment of one relevant person's representative to have ended and there being no one else who it would be appropriate to consult on the person's behalf. The data confirms the reported practice of 39C IMCAs being instructed when there hasn't been a previous relevant person's representative during the current standard authorisation.

Section 39D IMCAs are available where a person deprived of their liberty under a standard authorisation has an unpaid relevant person's representative (typically a family member or friend). They must be provided if requested by the person or their representative. They may also be provided if the supervisory body believes either may need support to understand and exercise their rights. Table 12 shows a breakdown of the different reasons why 39D IMCAs were instructed.

[3] Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - First report on annual data, 2009/10
[4] As above.

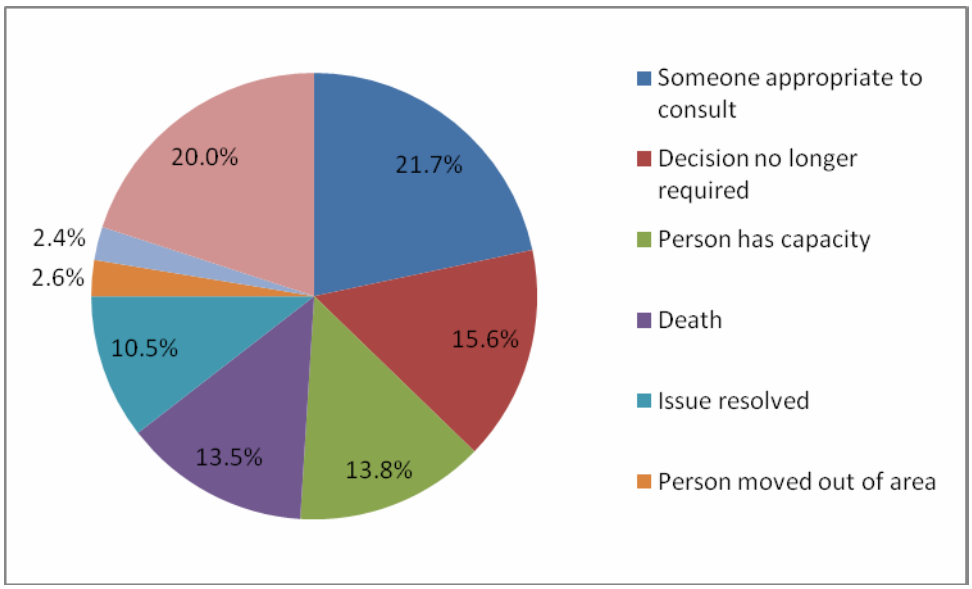
Table 12 Who 39D IMCAs were instructed to support



IMCA reports

IMCAs are required to produce a report for the person instructing them. There is a legal requirement for these reports to be taken account of when decisions are being made. IMCA reports were provided for 71% of eligible year 3 instructions which had been closed. Table 13 shows the different reasons why IMCAs did not produce reports for 1947 people. This accounts for 27.7% of closed eligible referrals in year 3. Whether a report was produced was not identified in the remaining cases (1.3%).

Table 13 Why IMCA reports were not provided



In 35.5% of cases the support of an IMCA was withdrawn as the person was found not to be eligible because either they had someone appropriate to consult (21.7%) or had capacity to make the decision for themselves (13.8%). In 13.5% of cases the IMCA's work ended because the person died.

Formal actions taken by IMCAs

IMCAs will at times have concerns about a decision being made, including how the person is involved in the decision making process. The expectation is that the IMCA will raise these concerns with those involved with the hope that differences can be resolved informally. Where this is not achieved the MCA allows IMCAs to take formal action. This may include formal complaints or an application to the Court of Protection.

Amongst the eligible case for year three, there were 14 formal complaints recorded. Eight were made against a local authority decision or process, the other six against an NHS decision or process. There were six cases where the action of IMCAs led to applications to the Court of Protection. It is not clear who these applications were made by (for example, the IMCA, the person, the local authority, or the NHS Body). The Code of Practice says that where there are disputes, local authorities or NHS bodies will normally make the application (8.8).

National advocacy qualifications

Year 3 saw the introduction of national qualifications in independent which are accredited by City & Guilds. The Department of Health supported the development of these qualifications. These qualifications include a taught element, the requirement to put together a portfolio of evidence; and an independent assessment of the portfolio and of the advocate.
There are two units which focus specifically on the IMCA role.
Unit 305, 'Providing Independent Mental Capacity Advocacy'
Unit 310, 'Providing Independent Mental Capacity Advocacy – Deprivation of Liberty Safeguards'.
The qualification is different from the original IMCA training. It requires IMCAs to be observed; their written work to be assessed and the need to demonstrate to an independent assessor that they have met the relevant learning objectives. It is expected that local authorities who have the responsibility to commission the IMCA service will increasingly require IMCAs to have successfully completed the assessment for these two units.

Good practice

The Department of Health supported the development of two good practice guides which were published during the third year of the service, namely, "Good practice guidance for the commissioning and monitoring of Independent Mental Capacity Advocate (IMCA) services" and "Practice guidance on the involvement of Independent Mental Capacity Advocates (IMCAs) in safeguarding adults".

Both were published by SCIE, the second jointly with the Association of Directors of Adult Social Services. They was developed in response to research undertaken by Redley et al (2008)[5] which showed a lot of variation of practice and identified requests for further guidance.

The Department of Health also funded is the IMCA Support Project at Action for Advocacy, which has produced two Best Practice Guides on IMCA report writing and IMCA instruction. The project also held the 2nd National IMCA Conference that was attended by a wide range of IMCA providers and a number of experts in the field.

Finally, the Department has part-funded the IMCA services' participation in a Quality Mark assessment by Action for Advocacy. This is a review of policies, practice and a sample of cases resulting in a report on the quality of the service provided by the IMCA organisation.

Together these initiatives should result in strengthening the ability of the IMCA organisations to empower and protect their clients.

[5] Redley, M., Platten, M., Keeley, H., Clare, I. and Holland, A. (2008) The involvement of independent mental capacity advocates (IMCAs) in adult protection procedures in England (PDF file): April 2007 to 31 March 2008, London: SCIE,

Appendix: IMCA Instructions by local authority

The table below contains the number of eligible IMCA instructions by local authority in year 3.

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
BARKING & DAGENHAM	6	39	21	5	9	12	92
BARNET	2	19	2	6	9	5	43
BARNSLEY	2	13	5	3	21	4	48
BATH & NORTH EAST SOMERSET UA	15	24	4	7	2		52
BEDFORD BOROUGH*	1	8	2		2	1	14
BEXLEY	1	8	2		2	2	15
BIRMINGHAM	45	104	50	5	19	4	227
BLACKBURN WITH DARWEN UA	2	8	4	3	16		33
BLACKPOOL UA	5	5	1	4	5		20
BOLTON	2	15	4	4	2	2	29
BOURNEMOUTH UA	6	42	10	4	13	3	78
BRACKNELL FOREST UA		2		15			17
BRADFORD	55	35	7	4	5	16	122
BRENT		25		1	6	1	33
BRIGHTON & HOVE UA	7	35	6	1	3	3	55
BRISTOL UA	26	64	10	6	16	13	135
BROMLEY	4	19	6			1	30
BUCKINGHAMSHIRE	2	27	5				34
BURY	8	9	9	2	7		35
CALDERDALE	4	14	5	2	5	1	31
CAMBRIDGESHIRE	8	32	19	2	7	3	71
CAMDEN	15	80	7	3	12		117

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
CENTRAL BEDFORDSHIRE *	1	8	3		4	1	17
CHESHIRE	17	30	12	1		4	64
CORNWALL	23	94	23	20	22	6	188
COVENTRY	10	26	12	4	4	3	59
CROYDON	10	30	10	2	3	1	56
CUMBRIA	20	41	24	5	14		104
DARLINGTON UA	5	10	11	3			29
DERBY UA	11	17	8	4	6	14	60
DERBYSHIRE	17	47	41	30	46	18	199
DEVON	12	72	14	7	7		112
DONCASTER	2	20	15	5	6	2	50
DORSET	14	45	4	1	9	6	79
DUDLEY	1	15	8			3	27
DURHAM	9	32	10	4	18	1	74
EALING	1	21	6		14	2	44
E. RIDING OF YORKSHIRE UA	3	18	9	5	1		36
EAST SUSSEX	32	88	41	9	27	5	202
ENFIELD	3	29	8	2	6	8	56
ESSEX	25	65	24	4	34	13	165
GATESHEAD	1	11	3	2	4		21
GLOUCESTERSHIRE	36	77	8	6	16		143
GREENWICH	1	5	4		1	2	13
HACKNEY	6	19	8	3	2		38
HALTON UA		3	5		1		9
HAMMERSMITH & FULHAM	2	25	3		4	2	36
HAMPSHIRE	21	43	10		15	23	112
HARINGEY		6	1	4	5	6	22
HARROW	2	10	2			3	17
HARTLEPOOL UA	4	8	4	2	4		22
HAVERING	7	39	9	5	1	5	66

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
HEREFORDSHIRE UA	9	5	5		5		24
HERTFORDSHIRE	20	56	30	7	7	15	135
HILLINGDON		12	2	1	5	1	21
HOUNSLOW	4	11			3	1	19
ISLE OF WIGHT UA		6	3	2		17	28
ISLINGTON	5	36	5	2	4	1	53
KENSINGTON & CHELSEA	7	19			8	3	37
KENT	31	59	1	20	8	93	212
KINGSTON UPON HULL UA	8	13		9		3	33
KINGSTON UPON THAMES	8	26			1	4	39
KIRKLEES	20	52	50	2	5	5	134
KNOWSLEY	1	10	7	1	1		20
LAMBETH	18	41	5		12	5	81
LANCASHIRE	25	42	19	22	45		153
LEEDS	26	92	48	16	18	5	205
LEICESTER UA	13	31	19	9	36	3	111
LEICESTERSHIRE	3	19	4	4	22	1	53
LEWISHAM	2	17	2	1	7	2	31
LINCOLNSHIRE	1	38	6	5	25	7	82
LIVERPOOL	32	48	7	12	19	6	124
LUTON UA*	3	23	12	5	3	1	47
MANCHESTER	28	89	4	8	16	23	168
MEDWAY TOWNS UA	1	9		1	2	21	34
MERTON		8	6	2	2	1	19
MIDDLESBROUGH UA	4	14	6	1	3	1	29
MILTON KEYNES UA		10	6	4	6	19	45
NEWCASTLE UPON TYNE	4	19	7	1	3		34

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
NEWHAM	2	20	7	2	7	3	41
NORFOLK	14	56	15	5	11	2	103
NORTH EAST LINCOLNSHIRE UA	3	9	1		7	9	29
NORTH LINCOLNSHIRE UA		5	1	1	5	1	13
NORTH SOMERSET UA	20	21	13	1	7		62
NORTH TYNESIDE	13	20	4	3	4	1	45
NORTH YORKSHIRE	8	41	12	16	15	8	100
NORTHAMPTONSHIRE	13	44	10	11	4	4	86
NORTHUMBERLAND	2	18	4		5		29
NOTTINGHAM UA	8	45	14	2	13	4	86
NOTTINGHAMSHIRE	9	30	11	8	29	3	90
OLDHAM		17	8	1	2		28
OXFORDSHIRE	14	35	20	4	12		85
PETERBOROUGH UA		2	1				3
PLYMOUTH UA	7	43	10	3	5	1	69
POOLE UA	4	20	7		3		34
PORTSMOUTH UA	8	18	2	1	5	4	38
READING UA		6	6	4	1	2	19
REDBRIDGE	1	7	1		1		10
REDCAR & CLEVELAND UA		6	1		1		8
RICHMOND UPON THAMES	2	15	1		1	5	24
ROCHDALE	4	7	7	1	2	28	49
ROTHERHAM	3	14	7	4	4	3	35
RUTLAND UA		1			2		3
SALFORD	8	14	1	2	4	1	30
SANDWELL	10	17	17	5	6	1	56
SEFTON	8	21	4	7	5		45
SHEFFIELD	13	53	20	16	5	4	111

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
SHROPSHIRE		5	4	3	4	1	17
SLOUGH UA	1	2	4	3	3	1	14
SOLIHULL	4	16	3	2	5	1	31
SOMERSET	9	34	17	7	10	2	79
SOUTHEND	2	12	9	1	5	0	29
SOUTH GLOUCESTERSHIRE UA	13	11	4	1	8		37
SOUTH TYNESIDE	2	22	9	9	8	1	51
SOUTHAMPTON UA	21	33	1		16	2	73
SOUTHWARK	4	17	9		15		45
ST HELENS	1	3	1		3		8
STAFFORDSHIRE	4	33	14	6	17	2	76
STOCKPORT	5	32	5	4	2	1	49
STOCKTON ON TEES UA	5	3	3	4	1		16
STOKE-ON-TRENT UA	20	15	10	2	13	5	65
SUFFOLK	22	76	26	51	14	1	190
SUNDERLAND	6	28	7	7	1	8	57
SURREY	81	129	13	12	16	11	262
SUTTON	5	28	9	4	1	2	49
SWINDON UA	1	14	4	3	7	2	31
TAMESIDE	8	15	5	9			37
TELFORD & WREKIN UA	3	5	3		3	1	15
THURROCK UA		9	7	1	2		19
TORBAY UA	8	27	6	7		1	49
TOWER HAMLETS	14	33	2	1	13	1	64
TRAFFORD		19	1	1	2		23
WAKEFIELD	15	24	28	1	6	9	83
WALSALL	7	18	10	2	3	4	44
WALTHAM FOREST	4	36	11	5	15	1	72
WANDSWORTH	3	46	16	1	7	2	75

	Serious Medical Treatment	Accommodation	Safeguarding adults	Care review	DOLS	Unknown	Total
WARRINGTON UA	3	7	7		6		23
WARWICKSHIRE	9	33	15	1	3	4	65
WEST BERKSHIRE UA	1	3	2	4	1		11
WEST SUSSEX	12	125	21	6	63	9	236
WESTMINSTER	11	30	1		10	1	53
WIGAN	10	34	14	1	21	7	87
WILTSHIRE	11	21	7	3	3	2	47
WINDSOR & MAIDENHEAD UA	1	6	1	5	13		26
WIRRAL	8	28	2				38
WOKINGHAM UA		2			2		4
WOLVERHAMPTON	1	7	13	1	8	2	32
WORCESTERSHIRE	17	26	16	6	13	5	83
YORK UA	5	29	8	6	4	3	55
Total	**1,316**	**4,087**	**1,326**	**617**	**1,214**	**613**	**9,173**

* These figures are being reviewed