The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role
We register care providers.
We monitor, inspect and rate services.
We take action to protect people who use services.
We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

Our values
Excellence – being a high-performing organisation.
Caring – treating everyone with dignity and respect.
Integrity – doing the right thing.
Teamwork – learning from each other to be the best we can.
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The Deprivation of Liberty Safeguards protect the rights of people in care homes and hospitals who lack the capacity to make certain decisions for themselves and are deprived of their liberty so that they can be given necessary care or treatment.
Foreword

The Deprivation of Liberty Safeguards exist to protect the rights of people in care homes and hospitals who lack the capacity to make certain decisions for themselves. They are an important protection to ensure that people who are in vulnerable circumstances and could be deprived of their liberty, are being treated and cared for with dignity and respect, as much as possible in line with their own wishes.

This is the Care Quality Commission’s sixth annual report on the implementation of the Deprivation of Liberty Safeguards since their introduction in 2009. Over the years we have highlighted a number of recurring issues.

In particular, in the early years of implementation we repeatedly raised our concerns that the numbers of applications were too low, and that people were potentially being unlawfully deprived of their liberty as a consequence. We have been pleased to see that since the Supreme Court ruling in March 2014, which broadened the understanding of when someone is being deprived of their liberty, there has been an increase in the number of applications. In 2014/15, 137,540 applications were received by local authorities, an increase from 13,715 in 2013/14.

The consequence of this increase is that there is now a backlog in local authority processing of applications. The cause of the backlog is a change in the interpretation of the law rather than a change in the way that
care is provided. Nevertheless, it exposes the very reason why the Deprivation of Liberty Safeguards exist; that is to ensure that the rights of people in care homes and hospitals who lack the capacity to make certain decisions themselves, and who could be deprived of their liberty, are being treated with dignity and respect as much as possible in line with their own wishes.

We recognise the pressure that local authorities face, and acknowledge that they and organisations such as the Association of Directors of Adult Social Services and the Local Government Association have responded to this situation by increasing their own activity and developing initiatives such as a tool for prioritising applications.

While we have found examples of hospitals and care homes doing things right, we are continuing to see huge variation in providers’ understanding and implementation of the Deprivation of Liberty Safeguards. We have found examples of people potentially being deprived of their liberty because the provider has not taken appropriate action. It is important for hospitals and care homes to have good leadership and a governance plan in place which demonstrates how they are able to deliver on their responsibilities.

It is clear that the current situation cannot continue. We welcome the Law Commission’s consideration of the Deprivation of Liberty Safeguards, to ensure that a long-term solution can be put in place. We hope that their final proposals will lead to improvements, including simplifying the process. This is important because of its critical role in ensuring the protection of people who have been deprived of their liberty so that we can all be sure their rights are respected.

Until reform occurs, it is important that the current system is complied with in the interests of the people the legislation was put in place to safeguard and, in particular, that the quality of people’s care is not compromised. We are pleased to see that the Government has recently established a National Mental Capacity Forum, which should play a key role in supporting these efforts.
The Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 provides the essential framework for people who need to make decisions on behalf of someone else who lacks mental capacity. It sets out who can take decisions, in which situations, and how they should go about this. This should ensure that they act in the person’s best interests and empower people to make their own decisions wherever possible.

Within this framework, the Deprivation of Liberty Safeguards are used to protect the rights of people who are deprived of their liberty so that they can be given necessary care or treatment. The Deprivation of Liberty Safeguards set out the processes that must be followed if a health and social care provider believes that they need to deprive someone of their liberty – including that care homes and hospitals must apply to local authorities for authorisation to do this. The local authority must make sure that a number of specific assessments are carried out before it can grant an authorisation. The Deprivation of Liberty Safeguards also set out the rights of a person or their representative to challenge an authorisation through the Court of Protection, and provide a way of monitoring a deprivation of liberty. Further information is available in the Mental Capacity Act and Deprivation of Liberty Safeguards Codes of Practice.

Other legislation may apply to the admission of people to health and care settings in other situations. For example, the Mental Health Act 1983 is the legal framework for compulsorily treating people with mental health conditions where it is in the interests of their health or safety or the safety of others to do so, alongside the safeguards required to protect their rights while receiving such treatment.

Applications increased tenfold from 2013/14 to 2014/15

137,540
Summary

There has been a tenfold rise in Deprivation of Liberty Safeguards applications in 2014/15

Since their introduction in 2009, numbers of applications from providers for authorisation to use the Deprivation of Liberty Safeguards had been consistently low. However, this changed in March 2014 following the ruling of the Supreme Court, which clarified the test for when people are deprived of their liberty. Since then, applications have increased tenfold from 13,715 in the year ending March 2014 to 137,540 by March 2015.

As a result local authorities, who are responsible for processing applications, are under significant pressure. We are pleased that the Association of Directors of Adult Social Services (ADASS) and some local authorities are taking action to deal with this rise in applications, for example through the use of new tools created by ADASS. However, we are also concerned by feedback that some local authorities are advising providers to delay, stagger or minimise the applications they are making, as this increases the likelihood of people being unlawfully deprived of their liberty.

There is still a significant backlog of applications received by local authorities, with 56,835 applications where the outcome was not decided by March 2015, compared with 359 across the previous year. The cause of this increase in the backlog is largely a change in the interpretation of the law rather than a change in the way care is being provided. It does not necessarily mean that people are any more or less at risk of receiving good or poor care. However, the backlog does mean that there is a delay in people who may be deprived of their liberty receiving the independent assessments, advocacy and representation provided by local authorities. These are essential to ensuring that people are only deprived of their liberty appropriately and that, consequently, they receive care which meets their needs and is consistent, as much as possible, with their wishes.

Providers’ use of the Deprivation of Liberty Safeguards is variable

As we highlighted in our 2015 State of Care report, strong leadership and governance will affect the quality of care that services provide.

These issues are consistent with our findings about the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards by hospitals and care homes. Through our inspections in 2014/15, we have found:

• Staff awareness, understanding and training of the Deprivation of Liberty Safeguards varies, despite the Supreme Court judgement clarifying the meaning of ‘deprivation of liberty’.

• Some providers do not have clear and up-to-date policies in place, with processes also not being consistently implemented. This includes making sure that people’s capacity is properly assessed and decisions are made in their best interests.

• We are continuing to find examples where providers may be unlawfully depriving people of their liberty.

• There is continued evidence of low notifications to the Care Quality Commission (CQC) about the outcomes of deprivation of liberty applications. Providers are legally required to inform CQC of Deprivation of Liberty Safeguards applications and their outcome together, when the outcome is known.
POSITIVE EXPERIENCE OF DEPRIVATION OF LIBERTY SAFEGUARDS
IMPROVING QUALITY OF CARE AND UPHOLDING HUMAN RIGHTS

Mr A had been residing in a particular learning disabilities residential home for more than 30 years. Following the Supreme Court ruling, the provider made a request for a Deprivation of Liberty Safeguards authorisation for Mr A.

When an Independent Mental Capacity Advocate (IMCA) visited Mr A, the staff and management of the home reported that Mr A would refuse to re-enter the home after a trip out, and it sometimes took them an hour to persuade him in again. He would also try to leave when the front door was opened for visitors. They said it was not related to his access to the community, which was once a week.

The IMCA asked the Best Interest Assessor to add a condition to the authorisation that the home should make more efforts to ensure Mr A had access to the community more regularly. Following a change in Mr A’s routine, so that he was getting out about five days a week with a member of staff he particularly trusted, Mr A stopped refusing to re-enter the home and trying to leave when visitors came in. The IMCA continued as his paid relevant person’s representative, closely monitoring his access to the community.

Overall, this means that people who use services are not consistently receiving the protections of the Deprivation of Liberty Safeguards, may not be having their human rights protected and may be receiving poor and inappropriately restrictive care that does not treat them with dignity and respect.

Improvement is needed across the health and social care sector

Implementing the processes under the Deprivation of Liberty Safeguards and wider MCA is essential to make sure that people are receiving treatment that is in line with the law and is in their best interests. This starts with making sure that staff always follow the processes for making decisions in the best interests of people who lack capacity. For example, for a person receiving care and treatment this means that they should receive an assessment of capacity where appropriate that is time and decision specific, that they are enabled to make the decision for themselves as much as possible, and that care options that are less restrictive than a deprivation of liberty are sought. In accordance with legal requirements the person, and any interested relatives or friends must, as far as possible, be part of the process; other people, such as ‘relevant professionals’, should also be involved as appropriate. Providers must also always seek an authorisation where a person may be deprived of their liberty, so that their interests are protected.

We recognise that some providers are doing this well, but we are concerned that we are continuing to find variation between – and sometimes within – providers’ understanding and implementation of the Deprivation of Liberty Safeguards. Care homes and hospitals must have clear and effective systems and policies in place for implementing the Deprivation of Liberty Safeguards, and must make sure that staff understand the Deprivation of Liberty Safeguards and receive relevant training.

We believe that the current pressures on the system are unsustainable, and that the variation we have found in providers’
practice in implementing the Deprivation of Liberty Safeguards is unacceptable. The Deprivation of Liberty Safeguards remain an important protection for individuals.

We welcome the Law Commission’s consideration on the process for authorising deprivations of liberty and await its final proposals for reforming the system. We hope that the final proposals will simplify the system and believe that national action will be needed to respond to the Law Commission’s findings when they are available. The Deprivation of Liberty Safeguards process is the main source of scrutiny and protection for people who may be deprived of their liberty, so simplifying this is essential to make sure that it can be more easily understood and implemented by all.

It is therefore important that providers and local authorities follow the current legislation and Codes of Practice to the MCA and the Deprivation of Liberty Safeguards to ensure that people’s rights are protected and that the care they receive is appropriate. Locally, action should continue to be undertaken to work on the backlog. We will continue to monitor the response of providers and the wider system going forward. We will continue to use our inspections and reports to encourage improvements in practice, and challenge providers if they are not meeting legislative requirements, which may include taking enforcement action.

Our actions and recommendations can be found at the end of this report.

POOR PRACTICE IN THE USE OF DEPRIVATION OF LIBERTY SAFEGUARDS

A woman, whose son had planned respite care throughout the year, was not made aware by the provider of a Deprivation of Liberty Safeguards application being made for him, and did not find out until she was contacted by the local authority as part of their assessment process. As a result, she stated:

“I was shocked and distressed to say the least; I knew of Deprivation of Liberty Safeguards and the reasons for it but nobody had related this to my son and his respite stays. It was the stuff of nightmares, [that is,] key professionals making decisions and not informing or involving me… I found out after the event, that the respite provider should have consulted with me about Deprivation of Liberty Safeguards… [As a result], there was no input from me at this crucial stage, only representation from the respite provider.”

She also reported some difficulties in her experience with the local authority. In particular, she felt that the telephone call she received from a Best Interest Assessor “was a cursory overview of the process, which left [me] more stressed and confused… It was a rushed call and I was not fully informed of what things were.” However, she reported that she had a good experience with a psychiatrist who was involved in the local authority’s process, finding that he ‘approached it from a human perspective’.

Overall, she felt “The whole thing (my son’s assessment) was just a box ticking exercise; it had to be done, so they did.”
Introduction

The Mental Capacity Act 2005 (MCA) makes sure that any decisions are made in a person’s best interests, setting out who can make decisions, and when and how these decisions can be taken, on behalf of someone who does not have capacity. It also ensures that people are empowered to make their own decisions wherever possible.¹

The Deprivation of Liberty Safeguards, introduced in 2009 as part of the MCA, are used to protect the rights of people who lack mental capacity and are deprived of their liberty so that they can be given necessary care or treatment, for example, for their own safety.² This can have a huge impact on the quality of care and life of a person who lacks capacity, ensuring they have a representative voice for their feelings and wishes where necessary, access to advocates and the opportunity to challenge an application or the conditions of an authorisation. It means that they have choices about the way they want to live and experience care and treatment.

The Deprivation of Liberty Safeguards set out the processes that must be followed if a health and social care provider believes that they need to deprive someone of their liberty, to ensure that this only occurs in the best interests of the person and that the availability of less restrictive options is considered. If a provider of a care home or hospital (‘managing authority’) suspects that a person using their service is being or will be deprived of their liberty, they must apply to the relevant local authority (‘supervisory body’) for authorisation.*

The local authority must make sure that a number of specific assessments are carried out before it can grant an authorisation. The Deprivation of Liberty Safeguards also set out the rights of a person or their representative to challenge an authorisation through the Court of Protection, and provide a way of monitoring a deprivation of liberty. The Deprivation of Liberty Safeguards apply to hospitals and care homes. Providers of other health and care services, such as supported living services, must apply to the Court of Protection for authorisation to deprive someone of their liberty in the course of offering care.

In March 2014, the Supreme Court clarified complex case law about the Deprivation of Liberty Safeguards in its landmark ruling on P v Cheshire West and Chester Council and P and Q v Surrey County Council. It ruled that a deprivation of liberty occurs when a person is under continuous or complete supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.³ In doing so, it expanded the previous understanding of when a deprivation of liberty takes place.

CQC and the Deprivation of Liberty Safeguards
Under the MCA, the Care Quality Commission (CQC) is responsible for monitoring the use of the Deprivation of Liberty Safeguards in hospitals and care homes. We have held this responsibility since 2009.

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* The relevant local authority is the local authority for the area in which the person is ordinarily resident.
2014/15 was the first year of monitoring the use of the Deprivation of Liberty Safeguards as part of our comprehensive inspection programme. We also look at the wider MCA. We are continuing work to embed this new approach.

Over the last year, we have:

- Continued to provide mandatory training for our staff on the MCA, including the Deprivation of Liberty Safeguards. This follows our commitment in last year’s report to make sure that inspectors are able to recognise good practice.
- Provided guidance on the MCA for our inspectors.
- Reviewed our systems for providers to submit required notifications to CQC (including about the Deprivation of Liberty Safeguards), to make sure that they are easier for providers to use and understand.
- Engaged with providers through our inspection processes, including identifying areas for improvement.
- Following our recommendations from last year, listened to the experience of people who use services as central to the inspections. This includes using Experts by Experience in our inspection teams.

Our five key questions – which we always look at in our comprehensive inspections – enable us to assess whether a service is safe, effective, caring, responsive and well-led. We look at the Deprivation of Liberty Safeguards and the wider MCA under the key question of whether a service is effective, and this will inform our decision when we are rating a service. Our findings also inform our judgement of whether a provider is well-led at board, trust or relevant leadership level. In preparing for inspection we review the notifications we receive on the Deprivation of Liberty Safeguards.

Where we find that the Deprivation of Liberty Safeguards are not being used correctly, and if this breaches a regulation, we can take enforcement action under the Health and Social Care Act 2008.4

From April 2015, our enforcement powers relating to deprivations of liberty have become stronger. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 make specific reference to deprivation of liberty and the need to seek authorisation. Where we find evidence that certain regulations have been breached, we can now go straight to prosecution without first issuing a warning notice where the risks to people who use services are immediate.† However, wherever possible we will work with a provider to improve, and will conduct a follow-up focused inspection to monitor improvement and offer advice and support.

In last year’s report, we considered how well the Deprivation of Liberty Safeguards had been implemented in the previous five years. We found that there had consistently been:

- A lack of understanding of the Deprivation of Liberty Safeguards by providers
- Low numbers of applications for authorisation (until the Supreme Court judgement)
- Regional variation in application rates
- A failure to notify CQC correctly.

We also highlighted the immediate impact of the Supreme Court judgement on Deprivation of Liberty Safeguards applications.

† In April 2015, new regulations known as the ‘fundamental standards’ took effect. Under these regulations, CQC can prosecute breaches of some regulations without first issuing a warning notice. Further information about CQC’s enforcement powers is available in the Enforcement Policy available at: www.cqc.org.uk/content/enforcement-policy
Focus for 2014/15 report
The roll out of our new inspection approach in 2014/15 has given us more data on how providers are implementing the MCA including the Deprivation of Liberty Safeguards. In this year’s report, we are able to place more emphasis on the findings of our own inspections. However, we recognise that we need to do more and are continuing our work to improve our inspection reporting so that we are consistently reporting on specific issues relating to the Deprivation of Liberty Safeguards.

This year’s report also looks again at the impact of the Supreme Court ruling.

As part of our research for the report, we have:

- Analysed a sample of 214 inspection reports out of all of the hospitals and care homes inspected in 2014/15 using our new approach, to identify key themes and case studies. This includes 190 reports from inspections of care homes (103 residential homes and 87 nursing homes), and 24 reports from inspections of acute, mental health and independent hospitals. Our findings for hospitals and care homes are not directly comparable.
- Analysed the enforcement actions we have taken in 2014/15.
- Looked at data on Deprivation of Liberty Safeguards notifications received by CQC.
- Collated data from external sources to support our monitoring findings, such as the Health and Social Care Information Centre, Office of National Statistics and the Court of Protection.
- Spoken to our Expert Advisory Group, as well as Best Interest Assessors, Independent Mental Capacity Advocates, local authorities and related voluntary sector and professional organisations.

Our report focuses on the impact on outcomes for people who lack mental capacity and may be deprived of their liberty, and highlights what we expect to happen to ensure improvement.
Deprivation of Liberty Safeguards and the wider system

Key points

• Following the judgement of the Supreme Court in March 2014, the number of Deprivation of Liberty Safeguards applications has continued to rise, with 137,540 applications made in 2014/15 compared to 13,715 in 2013/14.

• The increasing number of applications is creating a backlog in the system, with 56,835 unprocessed applications still pending at the end of 2014/15.

• We encourage local authorities to learn from good practice examples, where others have put in place effective measures to reduce the backlog of applications.
Issues within the wider system impact on the extent to which people are able to benefit from the protections that the Deprivation of Liberty Safeguards offer. This section focuses on system-wide issues, particularly the pressures resulting from the Supreme Court ruling, and what this may mean for people deprived of their liberty.

Rising numbers of applications

In previous reports, we have consistently raised the issue of relatively low numbers of applications to local authorities for Deprivation of Liberty Safeguards authorisation. However, in last year’s report we noted that there had been a significant increase in the first two quarters of 2014/15.

This increase in applications continued over 2014/15 – in total there were 137,540 applications in 2014/15, which was a tenfold increase from 2013/14 (figure 1). This is much higher than the 21,000 annual applications initially predicted by the government when the Deprivation of Liberty Safeguards were introduced in 2009. Applications are continuing to increase.*†

* This is based on voluntary quarterly data submitted to the Health and Social Care Information Centre. There are 93 local authorities who have submitted data for the last five quarters. For these local authorities, 33,000 applications were received in the first quarter of 2015/16, which is the highest number of applications received in the last five quarters.

† The Court of Protection has also experienced a recent increase in applications. Deprivation of Liberty applications to the Court increased from 109 in 2013, to 525 in 2014. There has been a consistent rise in applications to March 2015. This includes both applications made directly to the Court to authorise a deprivation of liberty for someone receiving care outside of a care home or hospital, and challenges to Deprivation of Liberty Safeguards authorisations given by local authorities. Specific data for each of these Court of Protection roles is not available.
Based on available data, over 80% of applications were from care homes (over 40% from nursing homes, and just under 40% from residential homes), and the remaining applications from hospitals (over 10% from acute hospitals, and around 5% from mental health and community hospitals). Some local authorities experienced a larger increase in applications than others, as the heat maps clearly demonstrate (figure 2 on pages 14 and 15).

Of the applications submitted in 2014/15, 62,645 were completed by local authorities and 52,125 of these were granted. The proportion of applications approved is higher than in previous years. However, we are concerned that the backlog of applications that we highlighted in last year’s report has increased significantly over 2014/15. By March 2015, 56,835 applications for authorisation had not been completed by local authorities. This means that a high number of people were likely being deprived of their liberty without the protection of external scrutiny – including the independent assessments, advocacy and representation that ensure people are only deprived of their liberty appropriately, and consequently that they receive care which meets their needs and is consistent as much as possible with their wishes.

Again, the backlog in applications has been a bigger problem in some areas than others. This has mostly happened in the areas with the largest increase in applications.

In 2014/15, 59% (37,110) of applications completed by local authorities for a standard authorisation were accompanied by an urgent authorisation. Urgent authorisations are issued by providers, where a person needs to be urgently deprived of their liberty as part of their care.
Figure 2 Deprivation of Liberty Safeguards applications by area, 2013/14 to 2014/15

Applications 2013/14

London
Why are application numbers increasing?
Applications have primarily increased because of the Supreme Court judgement which clarified – and broadened – the interpretation of when a person is deprived of their liberty. We have found evidence to support this in our inspections, with some providers stating that they have reviewed the cases of people in their care and made new applications for authorisations because of the Supreme Court ruling.

What action is being taken?
The Law Commission is undertaking a review of how deprivations of liberty for people who lack capacity should be regulated. This was announced in response to the Supreme Court ruling and the House of Lords’ finding that the implementation of the Mental Capacity Act 2005 (MCA) had not met expectations and the Deprivation of Liberty Safeguards are too bureaucratic and complex. At the time of writing, the Law Commission had just finished its consultation on a proposal to replace the Deprivation of Liberty Safeguards with a tiered, ‘protective care’ system that is aimed at improving outcomes for people with health and care needs, and their families and carers.10

We agree that the proposed ‘protective care’ scheme should better serve the needs of people affected, and provide a better framework for their families and representatives to become involved in the care being offered. However, we are concerned that some aspects of the current proposals are complex, and may not be easily understood by everyone who will be affected by them, including those involved in their implementation. We look forward to the Law Commission’s recommendations for reform after they have considered the consultation feedback. A draft Bill is expected to be published in 2016.11

Initiatives to process applications

Through the Association of Directors of Adult Social Services (ADASS), the Local Government Association and local authorities, we have heard about the methods that some local authorities are putting in place to deal with the increased volume of applications and reduce the backlog at a local level. These include:

- Using the ‘priority tool’ developed by ADASS to ensure urgent cases are processed as a priority.
- Using revised and streamlined Deprivation of Liberty Safeguards forms and guidance to speed up processes.
- Commissioning external agencies to focus on reducing the backlog, by providing additional Best Interest Assessors (BIAs) on a temporary basis.
- Training additional BIAs to be involved in the assessment process, to increase capacity within local authorities.

In addition, we have been told of local authorities and providers working together to address the backlog. For example, one local authority held workshops with providers to look at the issues around the backlog in their area and how they can work together better. In another, the local authority created a booklet to help providers understand the MCA and the Deprivation of Liberty Safeguards better.
Following the Supreme Court judgement, the Association of Directors of Adult Social Services (ADASS) set up a multi-agency, time-limited taskforce as an immediate and practical response to the increase in Deprivation of Liberty Safeguards applications. The taskforce particularly focused on workforce, funding and process issues.12

A local authority Deprivation of Liberty Safeguards lead was identified for each region and invited to join the ADASS-led taskforce, along with other partners. The taskforce provided a coordinated and joined-up response, as well as an opportunity for local authorities to share knowledge and good practice. It also produced a number of initiatives to respond to the rise in applications. These included a tool for prioritising applications that local authorities are regularly using to identify the cases that need to be assessed first.

The taskforce has now evolved into a regional leads programme that will continue to meet regularly, to share best practice and highlight emerging issues.

However, we are concerned that feedback, including from CQC inspectors and Independent Mental Capacity Advocates (IMCAs), suggests that some local authorities are advising providers to delay, stagger or minimise applications. Where this is happening, both individuals and providers do not have the benefit of the independent scrutiny. This is essential to make sure that people are only deprived of their liberty where appropriate, that their care is consistent with their best interests and as much as possible their wishes, and to consider whether less restrictive options are available. It also means that people are being deprived of their liberty without proper authorisation.

The importance of advocacy and representative roles

A number of advocacy and representative roles are a crucial part of the Deprivation of Liberty Safeguards to protect the rights of the individual. These offer representation, support or protection for the individual and their family to give them a voice within the system. This includes supporting challenges to authorisations or conditions.

Advocacy and representative roles

Appointed by the local authority, roles include:

- **Best Interest Assessor (BIA)** – appointed by the local authority as part of the authorisation assessment process, to determine if a person is being deprived of their liberty and if so, whether this is in their best interests.

- **Relevant person’s representative (RPR) or paid relevant person’s representative (paid RPR)** – a person appointed by the local authority to represent a person’s interests, when an authorisation is granted.

- **Independent Mental Capacity Advocate (IMCA)** – IMCAs may be instructed when an assessment is required for a standard authorisation where a person is only represented by a paid carer, or where there is a concern about a potentially unauthorised deprivation of liberty; to cover the role of the relevant person’s representative when there is a gap between appointments; and to support the person, or their relevant person’s representative, when a standard authorisation is in place including to challenge authorisations.
of authorisations (for example, changes for individuals where they wish to return home or access their community).

Anecdotal evidence suggests that financial support for these services is not meeting demand. For example, IMCAs in one area told us, “As far as we are aware there will be no extra money for IMCA services, despite the increase in need.” Stakeholders including the Local Government Association (LGA), ADASS and local authorities have also highlighted that resourcing constraints are a key reason why they are unable to reduce the backlog of applications. Resourcing of Best Interest Assessors (BIAs), who are required as part of the assessment process, is a particular concern.

We are aware that, in their joint submission to the government’s spending review, the LGA and ADASS have called for additional funding to address the pressures relating to the Deprivation of Liberty Safeguards.

In our wider engagement for this report, we have heard personal case studies where a representative appointed by a local authority was able to provide support as part of the Deprivation of Liberty Safeguards. These reinforce the positive role of the Deprivation of Liberty Safeguards in protecting the rights of individuals.

Improving care environment

Mrs X has been diagnosed with dementia and lives in a care home. She is immobile and dependent on staff. Her speech is minimal.

Staff thought that it was in her best interests for her to stay in her room as she became agitated in communal areas. The care home applied for a Deprivation of Liberty Safeguards authorisation and, as part of this, the local authority appointed a Best Interest Assessor (BIA) to conduct a best interests assessment. The BIA was generally satisfied with her care but unhappy that Mrs X was restricted to her room. He discussed this with Mrs X’s son.

As part of the assessment process, the BIA discussed various ways to improve her situation and lessen restrictions, and then discussed these with staff who were very positive in their response and willing to try them out. The care plan was amended to include new proposals, which included:

- Regular informal review meetings with family
- Varying Mrs X’s environment, for example by enabling access to the garden (this was also recommended as a condition to the authorisation).

Following the assessments, an authorisation period of six months was agreed to allow time for these changes to be tried and benefits reviewed. Her son was delighted with such positive action.
The role of the coroner

Guidance from the Chief Coroner, issued in December 2014, advises that a coroner’s inquest takes place automatically when someone dies with a Deprivation of Liberty Safeguards authorisation in place. In our engagement activities for this report, we heard about the difficulties and pressures that coroners are under to investigate deaths quickly, the increase in the volume of Deprivation of Liberty Safeguards inquests, and the distress and confusion that may be experienced by families and carers as a result. We will look into this further for our next annual report. In the meantime, we urge providers, local authorities and coroners to look at whether they can make their communications with families and carers clearer.

Finding less restrictive options

Mrs M, an elderly woman, suffered a fall and was admitted to hospital. She was then transferred to a care home rather than returning to her own house, as she had refused to allow her carers to come into her house on several occasions and the hospital felt that it would be unsafe for her to go back there.

Mrs M was very vocal about feeling like she was in a prison, and that she wanted to return to her own house. Her behaviour deteriorated rapidly and she became verbally aggressive and, at times, physically abusive. Over time, she became distressed and upset. She often asked others to take her home or attempted to leave the care home.

An Independent Mental Capacity Advocate (IMCA) who was appointed as Mrs M’s paid relevant person’s representative met with various relevant professionals about whether Mrs M could return to her house, citing that staying in the care home was not the least restrictive option. After some time, a multidisciplinary meeting was held and the IMCA advised the professionals that Mrs M wished to appeal her Deprivation of Liberty Safeguards authorisation to the Court of Protection. Eventually, a 24-hour care package was sought and Mrs M was able to return to her own house. She was able to stay in her house for five months with a live-in carer.

Improving quality of life

Mr Y, who was placed in a care home under the protection of the Deprivation of Liberty Safeguards, had been extremely agitated. An IMCA who was supporting him as his paid relevant person’s representative came to understand that he used to play pool and would still like to play pool as much as he could. She arranged for a condition to be added to the authorisation that allowed him to have planned accompanied visits to the pool hall at specific times in the week. This contributed to a change in attitude, made him happy, and contributed to his quality of life by enhancing his freedom and autonomy.
Findings from our inspections

Key points

- Good leadership and governance is central to ensuring that the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards are implemented effectively. However, while we have found some examples of positive practices, providers’ implementation of the MCA and Deprivation of Liberty Safeguards is not good enough; there is still variation both between and within providers.

- Staff still do not consistently understand the Deprivation of Liberty Safeguards.

- Some providers do not have clear policies and processes in place. Furthermore, policies and processes are not consistently implemented.

- We have found examples where people may be unlawfully deprived of their liberty.

- During 2014/15, we took enforcement action relating to the Deprivation of Liberty Safeguards, including in relation to breaches of Regulation 11, safeguarding, and Regulation 18, consent of the Health and Social Care Act (Regulated Activities) Regulations 2010.
As part of our inspection programme for care homes and hospitals, we look at and report on how providers implement the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards. We look to see that providers are acting within the principles of the MCA, have clear policies and guidance in place, and that staff have training on the Deprivation of Liberty Safeguards and know how to apply them in practice. A good provider will record in people’s care plans what support they have given to help people make their own decisions, or record how decisions have been made in the person’s best interests, and will consistently seek to use less restrictive options in how they deliver care.

This year, we have found some examples of good practice. However, some providers do not have consistent governance systems in place, and the variability means that the protections of the Deprivation of Liberty Safeguards are not being applied consistently.

Where we find that the Deprivation of Liberty Safeguards are not being used appropriately, we will work with a provider to improve wherever possible. We identify areas for improvement in our inspection reports and we may conduct a follow-up focused inspection to monitor how the provider has improved. If we find evidence that a provider has breached a regulation

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**GOOD AWARENESS AND RECORD KEEPING ABOUT THE DEPRIVATION OF LIBERTY SAFEGUARDS**

In one care home, we found that the registered manager used a chart called the ‘Resident [Deprivation of Liberty Safeguards] Application Record’. The chart listed various information, including:

- People’s names
- The date of the Deprivation of Liberty Safeguards application
- If the application had been granted and, if so, the expiration date
- If a notification had been submitted to CQC.

Furthermore, staff were aware of the requirements of the Deprivation of Liberty Safeguards. They had received training as a mandatory requirement.

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**POOR TRAINING AND PRACTICE IN THE DEPRIVATION OF LIBERTY SAFEGUARDS**

In one hospital, we found that training rates on the Mental Capacity Act, including the Deprivation of Liberty Safeguards, were poor across most wards.

Furthermore, in response to some incidents that had been reported, the trust had introduced keypads on all of its medical wards. However, our inspectors found that they had not considered how this impacted on patients’ liberty. There were no signs showing how people could access the code, or deprivation of liberty authorisations for those who were deemed to lack capacity.
for which we have enforcement powers, we can take action under the Health and Social Care Act 2008. Where enforcement action needs to be taken, a provider will have fallen below expected standards of treatment and care and in relation to the Deprivation of Liberty Safeguards. This may also mean that a person’s human rights and liberty have been breached.

During 2014/15 we have acted on our previous report’s recommendation to take enforcement action where necessary. For example, in action taken to prevent providers from operating six care home locations, there was evidence that breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010, which related to the implementation of the Deprivation of Liberty Safeguards and wider MCA, had occurred. This formed part of the basis on which we decided to take action, and part of the evidence we used to complete it.

In addition, we have issued 47 warning notices under Regulations 11 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010 (which related, respectively, to safeguarding people who use services from abuse and to consent to care and treatment) where we found evidence that the MCA was not complied with. Of these, in 29 cases there was some evidence that the provider had not specifically complied with the Deprivation of Liberty Safeguards.*

Some of the issues emerging from our analysis of these enforcement cases include:

- Lack of staff understanding or training about the Deprivation of Liberty Safeguards and wider MCA.
- Lack of authorisation applications being made to local authorities.
- Concern about implementation of processes such as capacity assessments, care planning and best interests decision-making.

Where we issue warning notices, we may undertake follow-up inspections to check whether improvement has occurred. We are pleased that providers are working with CQC, learning and taking action to improve their services where we have issued warning notices in relation to the MCA and Deprivation of Liberty Safeguards. In last year’s report (2013/14), 61% of providers that we took action against showed some improvement. This has increased to 74%. We have re-inspected 27 out of 29 (93%) care homes in 2014/15 where we took enforcement action specifically in relation to the Deprivation of Liberty Safeguards, and found improvements in 22 homes (76%). Improvements included better and higher uptake of training for staff, increased awareness and better practice around consent, and stronger care planning and recording systems.

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* Due to some variation in the recording of the MCA including the Deprivation of Liberty Safeguards in our inspection reports, these figures are a subset of our entire MCA and Deprivation of Liberty Safeguards enforcement activity in 2014/15.
**Issues emerging from our inspection reports**

To better understand how the Deprivation of Liberty Safeguards were implemented in 2014/15, we analysed a sample of inspection reports. For care homes, these were chosen as a representative sample and for hospitals, they were identified as providing more detailed evidence about practice in relation to the Deprivation of Liberty Safeguards.

Our analysis of this sample clearly demonstrates that providers’ practice in relation to the Deprivation of Liberty Safeguards varies. This is consistent with the findings in our recent 2014/15 State of Care report, in which we expressed concern that many people continue to experience large differences in the quality of care they receive – both between different services from the same provider and between different providers.

In our State of Care report, we also emphasised the importance of good leadership in delivering high-quality care, and we believe that leadership and governance is a critical factor in determining whether providers effectively implement their responsibilities in relation to the Deprivation of Liberty Safeguards. This affects key issues to be discussed further below, including:

- Making sure that staff understand the Deprivation of Liberty Safeguards and wider MCA so that they know their responsibilities.
- Having policies and processes in place, and implementing these, to support staff and make sure people are protected.
- Fulfilling requirements to seek authorisation from local authorities where people may be deprived of their liberty, and notifying CQC about the outcomes of these applications.

**Improving provider practices following enforcement action**

Inspectors visited a care home as part of a routine inspection in 2014 and found that staff showed a lack of understanding about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Among the issues identified:

- Staff said that they did not feel confident about recognising issues in relation to Deprivation of Liberty that might impact on the people who lived in the home and they had not completed training in these areas.
- Care plans did not indicate whether people had agreed or were able to consent to the care and treatment they received.
- The provider had not acted in accordance with legal requirements where people did not have the capacity to consent.

We sent a warning notice to the provider, which set out where they needed to improve. When inspectors visited the care home as part of a follow-up inspection they found that the provider had improved. There were procedures in place and there was clear guidance on the MCA, which included the steps they should take to comply with legal requirements. Staff had a good understanding of the MCA and Deprivation of Liberty Safeguards.
Overall, the variation we have found suggests that some providers do not have governance in place to make sure that the MCA and Deprivation of Liberty Safeguards are implemented effectively.

**Inconsistent training of staff and variable understanding of the Deprivation of Liberty Safeguards**

In 2014/15, we have found that staff are still not consistently trained on the MCA including the Deprivation of Liberty Safeguards. Where mentioned in our care home reports, only 61% (56 out of 92) ensured that all of their staff were trained and 71% (59 out of 83) ensured that managers were trained on the Deprivation of Liberty Safeguards. The proportion of staff trained in the Deprivation of Liberty Safeguards varied between hospitals, services and departments, with some figures as low as 7%, and others with 100% having completed training. Furthermore, training varied across staff levels, from security staff to clinical staff.

Where training was good, it was accessible, updated to reflect change, relevant to staff roles, and provided opportunities for peer learning and good management practice. Training delivery varied from inclusion at induction training, specific training schemes, e-learning, and regular updates for staff through meetings.

Staff did not always understand the MCA and Deprivation of Liberty Safeguards, even where we found evidence that training was provided. Understanding of the Deprivation of Liberty Safeguards and wider MCA within the hospitals we sampled was variable, even between different parts of the organisations. For example, one hospital received negative feedback overall about staff understanding of the MCA and Deprivation of Liberty Safeguards, but staff understanding was good in one core service.

Where recorded, 35% (58 out of 165) of care home reports demonstrated that staff did not understand the Deprivation of Liberty Safeguards and their roles and responsibilities in complying with the Safeguards. For example, in one care home inspection, a staff member told us they thought “everyone was on a [Deprivation of Liberty Safeguards authorisation], it’s a dementia floor”.

We recognise that since the Supreme Court’s judgement, providers will have had to undertake further work to make sure that staff receive training and fully understand the expanded meaning of deprivation of liberty. Where recorded, staff in 84% (42 out of 50) of care homes were aware of the judgement and understood how it should be translated into practice. In hospitals, staff knowledge and understanding of the ruling varied.

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**GOOD UNDERSTANDING OF CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS PROCESSES**

In one case, the registered manager of a care home told us that she was aware of the ‘four stage’ process to assess capacity. The manager was sharing her training with her staff so they understood the procedures that needed to be followed if people’s liberty needed to be restricted for their safety. Staff at this service also demonstrated a good awareness of the Code of Practice and confirmed they had received training in these areas.
People are at risk of not having their rights protected, and not being treated appropriately with dignity and respect and as much as possible in line with their own wishes, where staff do not understand the MCA and Deprivation of Liberty Safeguards. If staff are unaware of restrictions and who they apply to, or do not know the correct processes to follow, people will not necessarily be receiving safe and effective care. It is encouraging that some organisations have trained staff in relation to the MCA and Deprivation of Liberty Safeguards. However, we have raised our concern about levels of understanding in previous years, and are concerned by the variation in training and understanding that continues to exist. It is encouraging that all providers ensure that their staff receive appropriate training on and understand how to apply the MCA including the Deprivation of Liberty Safeguards.

Existence and implementation of policies is inconsistent, with some providers not well-led in regards to the Deprivation of Liberty Safeguards

Providers should have clear policies about the MCA and Deprivation of Liberty Safeguards in place, and these should be clearly displayed, accessible and communicated to staff. Processes must also be implemented. However, our inspection reports have shown that whether policies exist and are put into practice varies.

Where policies about the Deprivation of Liberty Safeguards were referenced, the majority of inspection reports for both care homes and hospitals noted they were in place. Generally, where we found policies in place they had information about the process to follow if staff considered a patient to lack capacity, what forms to fill in and information about where to obtain more specialist information. While some had also been updated to reflect the Supreme Court’s judgement this had not occurred in all cases.

However, we are concerned to find evidence that some providers still do not have clear, up-to-date policies and processes in place. For example, we identified that one hospital had a policy that was drafted in 2009 and was due for review in 2010, but had not been updated to reflect recent legal changes. This is not acceptable as it means that people are at risk of being unlawfully deprived of their liberty and not being cared for appropriately with dignity and respect.

We are also concerned that policies and processes are not being consistently implemented. Our inspections have found variation in relation to:

- How processes were followed in care planning to ensure that decisions made under the MCA were in people’s best interests based on their individual needs (including with involvement of relevant professionals and family members).
- Assessments of mental capacity.
- How these issues, along with authorisations where someone was deprived of their liberty, were recorded in care plans.

This is reinforced by data from the Health and Social Care Information Centre, which found that one of the most frequent reasons for Deprivation of Liberty Safeguards applications not being granted was that providers had not satisfied the mental capacity requirement (in 2,895 applications). These processes are critical to empowering people to make their own decisions within the spirit of the MCA and, where individuals are not able to do so, ensuring that decisions and the care provided are reflective of individual needs and that less restrictive options are sought.
Provider boards and management teams are responsible for making sure that relevant policies and processes about the MCA including the Deprivation of Liberty Safeguards are in place and effectively implemented.

Potential unauthorised deprivations of liberty
Although it is not CQC’s role to review individual cases, we are concerned that inspectors are continuing to find examples of individuals potentially being deprived of their liberty, without the provider having applied for authorisation to do so. This is despite the clarity offered by the Supreme Court’s judgement and subsequent rise in applications made to local authorities.

Worryingly, we found examples of possible unlawful deprivations of liberty in as many as 56 of the care home reports in our sample. In one care home, inspectors found, “There had been no applications for Deprivation of Liberty Safeguards for people using the service at the time of our inspection, despite the manager attending recent training, and despite us identifying people at the service who may be unlawfully deprived of their liberty.” We also identified examples of potential unlawful deprivations of liberty in some hospitals.

Providers must always ensure that their staff seek less restrictive options for individuals in their care, and that they are able to recognise where someone may be deprived of their liberty. Where it is appropriate to deprive someone of their liberty, providers must seek authorisation from the relevant local authority to make sure that there is independent scrutiny to protect people’s interests and that the care they receive is appropriate.

Low notifications to CQC
Providers are required to notify CQC about any application that has been made to deprive people of their liberty under the Deprivation of Liberty Safeguards (or by applying directly to the Court of Protection) and its outcome, at the same time when the outcome of the application is known. This includes where the application is withdrawn because the person regains capacity, is detained under the Mental Health Act 1983, moves out of area, or the application is no longer required for any other reason.

In 2014/15, we received 34,760 notifications from providers. Again this year, this is much lower than the number of notifications we would expect to have received compared to the number of decisions made by local authorities and withdrawals in the same time period.

Before our inspections, we check whether we have received notifications from providers. This enables inspectors to specifically consider the care of people subject to authorised deprivations of liberty, and whether the provider is complying with conditions applied to the authorisation. When we are not notified, our ability to fulfil our statutory duty to monitor the Deprivation of Liberty Safeguards, and to make sure that people’s rights are being protected and to check that they are receiving appropriate care, is greatly reduced. Where we find evidence that these notifications to CQC have not been submitted, it could affect the ratings given to the service or result in enforcement action.
CQC actions and recommendations

What providers must do

• Take action to meet the requirements of the MCA, in line with the Codes of Practice for it and the Deprivation of Liberty Safeguards. This includes making sure that their staff understand the MCA including the Deprivation of Liberty Safeguards, have access to training, consistently undertake capacity assessments where it is appropriate for them to do so and apply best interests decision-making processes for people who do not have capacity.

• Make sure that they have in place clear policies and processes relating to the Deprivation of Liberty Safeguards.

• Continue to request authorisations when they think that people may need to be deprived of their liberty, while always seeking less restrictive options to meet individual needs.

• Make sure that they notify CQC about Deprivation of Liberty Safeguards authorisation applications and their outcome (when the outcome is known), so that we can fulfil our monitoring role.

We also recommend

• Local authorities learn from good practice initiatives being put in place by other local authorities, through the Association of Directors of Adult Social Services (ADASS) regional leads programme, and to continue to use available tools such as those created by ADASS.

• Local authorities must not advise providers to delay or inappropriately minimise their applications as this increases the likelihood of people being unlawfully deprived of their liberty.

What we will do

• Clearly define what ‘good’ looks like in relation to the Deprivation of Liberty Safeguards.

• Continue to use our inspections and reports to encourage improvements in practice.

• Continue to challenge providers if they are not meeting legislative requirements, which may include taking enforcement action.

• Continue to ensure that our inspectors are able to recognise good and poor practice, and to improve our own reporting and recording about the MCA, including the Deprivation of Liberty Safeguards.

• Continue our own work and engage with stakeholders to improve the notifications process for providers.

• Continue to engage with the Law Commission as they carry out their review.
References

Appendix: Deprivation of Liberty Safeguards Advisory Group

We would like to thank members of the Deprivation of Liberty Safeguards Advisory Group for their contributions to the development of this report:

Alison Cobb, Mind
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- Independent Mental Capacity Advocates
- Best Interest Assessors
- Voluntary and community sector organisations
- Family members of people who have been deprived of their liberty.
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