

# The state of health care and adult social care in England 2015/16

THE DEPRIVATION OF  
LIBERTY SAFEGUARDS



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# The Deprivation of Liberty Safeguards

## Key points

- We have seen examples of good practice in all sectors, including individual providers who have improved after we have taken enforcement action. Providers who applied the Deprivation of Liberty Safeguards (DoLS) well had a culture of person-centred care, robust policies and documentation of DoLS procedures, and good leadership in place to provide a focus to staff understanding of DoLS and how to apply it.
- There is variation in the effective application of DoLS both between providers and within individual providers across the different core services that we inspect. This could lead to individuals not receiving care that is in their best interests.
- Not enough providers are applying capacity assessments effectively. Many providers made assumptions that individuals lacked capacity without having carried out or documented assessments. Some providers used the 'blanket approach' to capacity assessments, which suggests that their focus may be more on managing organisational risk than delivering person-centred care.
- Lack of staff training remains a problem. Although many staff showed good understanding of the DoLS and wider Mental Capacity Act 2005, there were many other services where training and staff understanding were not good enough.

# Introduction

The Mental Capacity Act 2005 (MCA) exists to protect and empower individuals who are unable to make some or all of their own decisions. It ensures that 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.

Within the framework of the MCA,<sup>f</sup> the Deprivation of Liberty Safeguards (DoLS) are used to protect the rights of people who are deprived of their liberty so they can receive necessary care or treatment. The DoLS apply in hospitals and care homes. A deprivation of liberty is described as:

- 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.

As set out in the Deprivation of Liberty Safeguards Code of Practice, DoLS provide a legal process to ensure that, where it is necessary to deprive a person of their liberty, it occurs in the person's best interests. The DoLS ensure that people who lack capacity and are deprived of their liberty have a representative voice, access to advocates and the chance to challenge

Footnote:

<sup>f</sup> Note that in this section, we comment on the application of the MCA as it relates to the use of DoLS. We do not consider other issues relating to the MCA.

## Improvements in practice

In our inspection reports in 2015/16, we saw examples of good practice in all sectors. We have also seen examples where individual providers have been able to improve, particularly where we have re-inspected them after previously highlighting concerns.

whether their liberty should be deprived.

Care homes and hospitals must apply to local authorities to ask if they can deprive someone of their liberty. The DoLS set out the processes that must be followed. The local authority must make sure that a number of specific assessments are carried out before granting authorisation. A hospital or care home can grant an urgent authorisation for a short timeframe in exceptional cases.

CQC is responsible for monitoring the use of the DoLS in hospitals and care homes. Each year, we report on how they are being implemented. Our inspectors look at both DoLS and the wider MCA in inspections, and our findings inform the ratings we give to providers. We are committed to working with providers to show them where they are doing well, and what they need to do where they may need to improve. We also challenge providers by taking enforcement action where we have concerns that legal requirements are not being met. We take seriously our role to carry out enforcement where needed to protect the human rights, dignity and wellbeing of people receiving care.

In previous years, we have highlighted the variation in how effectively providers implement DoLS. In 2015/16, our inspection findings showed evidence of improvement among providers that have been re-inspected. We saw pockets of good practice of DoLS specifically, and the wider MCA generally. However, some hospital and care home providers were still not adequately implementing their responsibilities and improvement is needed.

### Improvement among providers

We have particularly seen examples of improvements in adult social care. We looked at a sample of care homes whose ratings had improved. The vast majority were not meeting the DoLS and wider MCA requirements when we first inspected, but were doing so when we re-inspected.

## DoLS: the broader context

In March 2014, the Supreme Court 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 lacks capacity to consent to these arrangements.

In our previous reports on DoLS, we have highlighted the challenges that have been faced since this judgement, including the unprecedented number of applications for authorisation.

These challenges have continued. Data from NHS Digital shows that, in 2015/16, applications received by local authorities rose to the highest levels ever, to 195,840 applications. This compares with 137,540 received in 2014/15. Of the 105,555 applications that were processed in 2015/16, 76,530 (73%) were approved. There has also been a large increase in the number of applications with urgent authorisations: 95,495 (49%) of the applications received in 2015/16. In addition, we are aware that there was a general upward trend for section 21A applications (where the person to whom the application relates challenges a standard or urgent deprivation of liberty authorisation) to the Court

of Protection in 2015/16.

Providers of other health and care services outside of hospitals and care homes, 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. We are also aware that Deprivation of Liberty applications to the Court of Protection continued to rise, more than doubling from 525 applications in 2014 to 1,499 in 2015. This upward trend continues in 2016.

The situation has continued to place significant pressure on local authorities. Our inspectors have noted that local authorities have been overwhelmed with applications.

Discussions with the Association of Directors of Adult Social Services and the Local Government Association have highlighted some of the challenges that local authorities are facing. For example, there are challenges not only in responding to new applications for authorisation, but also in re-assessing and (where justified) authorising applications following expiry of existing authorisations, and being able to identify and appoint enough representatives

(such as Relevant Person's Representatives and Independent Mental Capacity Advocates) to support people who may be subject to a DoLS authorisation. Initiatives continue to be put in place to help address this, such as sharing of good practice by local authorities, but significant challenges remain.

This situation affects people who use services. For example, as we reported last year, the backlog may lead to delays in the independent assessments, advocacy and representation provided by local authorities. These are essential to make sure that people are only deprived of their liberty appropriately and that they receive care that meets their needs and is consistent, as much as possible, with their wishes.

The existing scheme has been criticised for its complexity and the sharp questions it raises about sustainability and costs. The Department of Health has asked the Law Commission to carry out a review of how deprivation of liberty for people who lack capacity should be regulated. We hope that their final proposals, due to be published in December 2016, will lead to improvements.

We also found improvement where we have taken enforcement action. When we re-inspected care homes that had previously had enforcement action relating to a breach of the need to seek consent,<sup>g</sup> in relation to DoLS practice, the vast majority had successfully rectified their breaches and were now applying DoLS correctly. In some cases, however, further improvement was needed. Of care homes that had faced enforcement action for breaching the requirement to protect people who use services from abuse and improper treatment,<sup>h</sup> the majority had shown enough improvement when we re-inspected. Where improvements were still needed, most of our inspection reports identified a need to improve staff understanding of DoLS through more training.

It is important to draw learning from good practice to encourage other providers to improve. Where we saw evidence of DoLS and the wider MCA being applied well, the following factors were common.

### **A culture of person-centred care**

Person-centred care is defined, from the point of view of those receiving care, as “I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes that are important to me”.

This principle is central to the MCA. Providers that we considered, during inspection, to be ‘good’ at delivering person-centred care appeared to have a

higher level of understanding of DoLS and the wider MCA than those who were not.

Importantly, staff assessed individuals properly, avoided applying blanket approaches to people’s capacity assessments and took account of individuals’ choices, preferences and needs. While not common, our inspectors also highlighted that some providers were proactive in seeking support where relatives were not able to be involved in best interests decision-making – such as involving independent advocates or representatives appointed by the local authority. All of these factors would have a significantly positive effect on people’s experiences and the quality of care they receive.

### **Robust policies and documentation of DoLS procedures (and the wider MCA)**

In examples of mental health trusts that were applying DoLS and the wider MCA effectively, staff were supported by clear policies and procedures in place. For example, in one mental health trust, staff were provided with clear guidelines and a checklist to make sure that capacity assessments were carried out correctly and escalated for specialist advice where necessary.

Staff were aware of the policies on the MCA and DoLS and could refer to them if needed. In one community mental health provider for people with a learning disability or autism, a multidisciplinary approach was taken to best interests decisions. Treatment records showed evidence of informed consent and, where appropriate, assessment of capacity. In an acute hospital, audits had been carried out in wards. They recognised the importance of full completion of the

Footnote:

g Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

h Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## **Better training leads to improvements**

One provider had made significant progress in implementing DoLS and the wider MCA since our last inspection. Previously, we had reported staff “not really knowing what it [DoLS] was”. When we re-inspected, we

found that training had been completed, assessments of people’s capacity to consent to necessary arrangements were being made, and authorisation was now appropriately sought from the local authority. The manager

in charge of the service said that the main driver for improvement in their handling of DoLS applications was the increased understanding across the service that they had fostered through training.

DoLS application forms, and a scoring system was used to motivate the team to ensure good practice.

Having clear policies and procedures in place helps to ensure that people consistently receive care that safeguards their rights, that their care is more reflective of their needs and wishes, and that their liberty is restricted only if it is necessary and proportionate.

### Good leadership

We found examples of DoLS and the MCA being implemented well where there was specific (often senior) staff with expertise driving change and ensuring staff engagement. Acute hospital trusts that did well tended to identify senior members of staff to lead and provide a focus to staff understanding of DoLS, and to improve its implementation. For example, one inspector highlighted a clinical lead in critical care with a particular interest in DoLS. This person

developed a bespoke management tool for critical care DoLS, in partnership with the trust's legal team and their professional body.

Leadership was often important for establishing good quality training and widespread organisational understanding. Inspectors described these trusts as likely to have a culture that valued staff being actively engaged, and understanding the needs of patients through the delivery of person-centred care.

We also saw some evidence of the importance of leadership in adult social care. In one provider, staff 'champions' received additional training in a range of areas such as mental capacity, and supported other staff to ensure best practice. In contrast, we found that the absence of a registered manager could lead to poor practice. We looked at a sample of services rated as inadequate for effectiveness, and found that many did not have a registered manager in post.

## Continuing variation

While we found examples of good practice in how DoLS and the wider MCA are applied, we also found examples of poor practice.

In acute hospital and mental health trusts, there was variation both between providers and within individual providers across the different core services that we inspect. While some core services showed good practice, others did not, suggesting that oversight across the trust was not consistent. Additionally, analysis indicated that some trusts, particularly large ones, may have variation in their practice across different locations. For example, a main site might

have a good grasp and application of DoLS, while other sites may not be meeting their obligations well.

In adult social care, training and staff understanding and documented use of advocates, were recorded more consistently in residential homes than in nursing homes. In contrast, good practice in best interests decision-making, involvement of family and other professionals in best interests decision-making, and reviews of DoLS assessments taking place when needed, were recorded more consistently in nursing homes than in residential homes.

### Exceptional with applications

Inspectors described one mental health hospital as "exceptionally" good with DoLS applications. The applications were individualised and comprehensive, with each one telling a story about the patient. The number of restrictive interventions had reduced dramatically in recent years, with lots of work having been done around restraints, medicines and seclusion. This was largely down to staff training and support.

### Followed on care journey

In one acute hospital, patients with a learning disability sometimes held a 'care passport'. They brought this into hospital with them to enable staff to have a greater understanding and insight into their choices, preferences and needs. The learning disability nurse would follow the patient through their care journey through the hospital, develop a care plan that included the use of advocacy, and make sure that mental capacity and consent were considered.

Specifically, there was variation in how well DoLS were being applied in the following areas.

### **Variation in levels of staff training and understanding**

There were some services in all sectors where staff showed good understanding of the DoLS and the wider MCA, and were clear about the procedures for applying them appropriately. However, there were many other services where training and staff understanding were not good enough.

In all sectors, we were more likely to see a higher level of training and understanding of DoLS in services rated overall as outstanding, compared with those rated inadequate.

With a small number of exceptions, staff working in the outstanding adult social care services understood DoLS and incorporated it in everyday practice. There was a very small minority of staff with an understanding of DoLS in services rated as inadequate. In adult social care, staff training in DoLS was much more widespread for the outstanding care homes in our sample, compared with the inadequate care homes we looked at.

### **Variable practice in how capacity assessments and best interests decision-making are carried out and documented**

In providers across all sectors, we found variable practice in the implementation of capacity assessments and best interests decision-making. While we have previously highlighted some appropriate practice, we have also found some areas of concern.

In particular, many providers made assumptions that individuals lacked capacity without having carried out or documented assessments, or they assessed individuals as lacking capacity without ensuring this was time and decision-specific. For some providers, the 'blanket' approach to capacity assessments suggested to our inspectors that their focus may be more on managing organisational risk than delivering person-centred care. Some providers also made blanket assumptions that individuals with particular conditions lacked capacity, such as people living with dementia.

There was also variation in the documentation of evidence of family and other professionals being involved in best interests decision-making. Evidence of MCA compliant

decision-making, including the involvement of family or friends, was recorded in a majority of care homes rated as outstanding overall, but only in a very small minority of those rated as inadequate overall.

### **Variable practice in the management of applications for authorisation to deprive a person of their liberty**

We know that many providers are applying for standard authorisations to deprive people of their liberty, and seeking urgent authorisations where needed. However, our inspection reports identified some continuing variable practice in how providers are managing these processes.

In some of our inspections, and also through our stakeholder engagement, we found evidence of different issues emerging, including some that we have highlighted in previous years:

- instances where individuals appear to potentially have been deprived of their liberty unlawfully – such as without the provider seeking authorisation to do so or where authorisations had expired
- providers taking a 'blanket approach' to authorisation applications, including submitting applications for individuals with capacity
- decisions about DoLS (including conditions of authorisations) not communicated appropriately (such as recording them in an individual's care plan) and/or complied with
- concerns about the use of urgent deprivation of liberty authorisations, including lack of understanding and continued use beyond their expiration dates
- authorisations not being kept under review.

For example, in one surgery ward of an acute hospital, the safeguarding office was unable to provide the relevant DoLS authorisation information about individual applications. Also, there was no formal way of checking if there were conditions attached to individual applications. This was identified as a significant risk to the organisation and it showed a disconnect between the safeguarding team and clinical staff. In such cases, this would result in the patient receiving poor care. Furthermore, it could mean people being restricted inappropriately and unlawfully.

We recognise that providers are experiencing challenges where the pressures being faced by local authorities delay the outcome of their applications.



However, this does not account for all of the issues noted above. Overall, these issues are concerning as they mean that some individuals may not be receiving care that is a less restrictive option and in their best interests – and, in some cases, that they are missing the opportunity for independent scrutiny and challenge to make sure this is the case.

Staff must always seek less restrictive options for individuals in their care, and be able to recognise where someone may be deprived of their liberty.

## Learning from good practice to reduce variation

Overall, we saw some examples of good practice in implementing DoLS and the wider MCA in adult social care, mental health trusts and acute hospitals. Some providers that showed poor practice in their use of MCA/DoLS have made the necessary improvements to safeguard the rights and needs of people who use services.

However, there continues to be large variation in practice. There needs to be a greater effort to train staff on DoLS and how to use them effectively, as well as maintaining the right procedures and processes. This is critical for ensuring that people receive good quality care and treatment that is in their best interests, and that they are not deprived of their

liberty unlawfully. It is important that we make sure that everyone, irrespective of their mental capacity, can experience care that considers their needs and preferences. While there are significant challenges in the system, until reform takes place it is important that the current system is complied with to protect people's interests, and to avoid compromising the quality of the care they receive.

Where it is appropriate to deprive someone of their liberty and it is shown that the person does not have capacity for the relevant decision, 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 the least restrictive possible. Information about authorisations and any associated conditions should also be clearly recorded and accessible to staff, to help ensure they treat people with their best interests.

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We encourage providers to learn from those that have successfully delivered a person-centred approach. They should ensure there is good leadership that fosters a strong culture of the wider MCA and DoLS, and provides the support that staff need.

### Good management enables faith practice

A woman with strong religious beliefs was admitted to a care home. The home applied to the relevant local authority to deprive her of her liberty, in her best interests. This was authorised under DoLS.

While being deprived of her liberty, the woman had a strong desire to continue to practise her faith. The care home tried different options, consulting with a family member (who was also her Lasting Power of Attorney for health and welfare) to minimise the possible restrictions on her human rights,

despite the need for authorisation. However, the lady concerned was distressed by each option and did not find them suitable.

A best interests meeting was held to find a solution. A decision was made that attempted to minimise her anxiety about "strangers" taking her to church and that also gave her more freedom to live as she wished. The care home and the woman's daughter involved the church community, and the lady is now picked up by the minister at the care home and taken to church for a communion service. She is

accompanied by a carer, who does not wear a uniform, reducing the likelihood of her being singled out among the congregation.

To minimise as far as possible restrictions on her human rights, the provider, together with her Lasting Power of Attorney for health and welfare, sought ways to enable her to attend her church as she wished to do. This has enabled her to continue to practise her faith as she wishes, has increased her happiness and has had a positive effect on her wellbeing.

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