

# Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13



# 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 monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

## **Our principles:**

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

# The Deprivation of Liberty Safeguards

## Leading to reduction of restraint

Mr D is living in a residential home which has a minibus to collect clients coming to their day centre. Mr D always wanted to go on the bus and would fight to get on.

The home gave itself an urgent authorisation under the Deprivation of Liberty Safeguards to stop him doing this, as they believed it was in his best interests.

The best interests assessor, in exploring his situation, discovered that Mr D had been a bus conductor in the past. Because of his dementia, he thought he was again. She suggested that to avoid the need to upset him, even to the point of having to restrain him, Mr D should travel on the bus with an escort to collect the other people.

This focus on Mr D enabled the home to understand his personal history and accommodate this into his care plan. He is no longer prevented from going on the bus, and he is not restrained in any way: an authorisation is not needed.

The staff of the home learned to decide best interests holistically, in accordance with the Mental Capacity Act, and to avoid restraint wherever possible.

# Contents

The Deprivation of Liberty .....	1
Foreword .....	3
Summary .....	4
Introduction .....	8
01 Patterns of use of the Deprivation of Liberty Safeguards .....	13
02 Monitoring the use of the Deprivation of Liberty Safeguards through inspection of care homes and hospitals .....	19
03 Monitoring of supervisory bodies .....	26
04 Better understanding the experience of people who have been the subject of authorisation applications.....	42
Conclusions .....	50
Appendix A: Developments in case law .....	53
Appendix B: Resources on the Mental Capacity Act, including the Deprivation of Liberty Safeguards .....	58
Appendix C: External Advisory Group .....	60

# Foreword



The Mental Capacity Act (MCA) is a crucial framework for good practice in the care and treatment of people in vulnerable circumstances. It explains how to strike the balance between respect for fundamental rights to liberty and autonomy with the need to protect people when they lack capacity to make certain decisions. Founded in human rights law, the MCA makes clear that any actions by others must be in the best interests of the person, within a framework of promoting and protecting the person's right to liberty.

The MCA has been the focus of much attention during the past year, for example in the House of Lords and the Supreme Court. A key message from CQC's work, and from the evidence to the House of Lords Committee examining the MCA, is that the Act is still not understood and implemented consistently across health and social care services. This is not good enough. The MCA has been in effect since 2007, and the Deprivation of Liberty Safeguards since 2009. With regard to our wider regulation and inspection remit, we are clear that there is no excuse for services providing health or social care to anyone over 16, not to have achieved clear policies and practice that comply with the MCA. This should include in particular an emphasis on reducing restriction and restraint of vulnerable people lacking capacity, and an informed use of the Deprivation of Liberty Safeguards.

CQC is increasing its efforts to promote implementation of the MCA through our new approach to regulation across all sectors. During the past year we have set out a new vision and direction for the Care Quality Commission in our strategy for 2013 to 2016, Raising standards, putting people first. The strategy makes explicit CQC's commitment to strengthening our focus on the Mental Capacity Act including the Deprivation of Liberty Safeguards. Our three Chief Inspectors, appointed this year, will ensure that MCA principles are hardwired into our new model for regulation and inspection in all services registered with CQC.

A central theme in this report is the value of partnership approaches to identifying and implementing improvements in practice. In the context of our monitoring programme for the Deprivation of Liberty Safeguards I would particularly like to acknowledge the increasing value we place on collaboration with local authorities in their role as supervisory bodies. I am also very grateful for the continued support of those expert individuals and partner organisations who give time to our external advisory group – supporting, informing and challenging this work. Collectively we can shine a light on poor practice to improve standards of care for people, identify examples of good practice wherever we find them and promote learning across the system.

**David Behan**  
Chief Executive

# Summary

The Deprivation of Liberty Safeguards were introduced in 2009. They are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves. The MCA provides the essential framework of guidance for people who need to make decisions on behalf of someone else. It sets out who can take decisions, in which situations, and how they should go about this – making sure they act in the person’s best interests and empowering people to make their own decisions wherever possible.



## CQC's role

We have a duty to monitor the operation of the Deprivation of Liberty Safeguards in England. A Code of Practice sets expectations for us to monitor them through our existing programme of inspections, and to report annually.

This is our fourth annual report on the Deprivation of Liberty Safeguards.

There are no direct enforcement powers associated with the role. If we find that the Deprivation of Liberty Safeguards are not being used correctly, we can however take action under the Health and Social Care Act. A number of the Health and Social Care Act regulations contain references to elements of the Deprivation of Liberty Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

## Our findings

The number of applications has increased every year since the Deprivation of Liberty Safeguards were introduced in 2009, but the rate of increase in 2012/13 was smaller than previous years. There were 11,887 applications to use them in 2012/13, a 4% increase on the 11,393 applications made in 2011/12.

The number of authorisations also increased, although again this rise was less than previous years. There were 6,546 authorisations granted compared to 6,339 in 2011/12. Significantly, application rates have increased sharply since the Deprivation of Liberty Safeguards were introduced for those aged 75 and over, while rates for those aged 18 to 64 have levelled out. The reasons for this might include the aging of the population and the high numbers of people living with dementia, but we will look for ways to explore this further.

Application rates continue to vary by region as they have over the past four years of the Deprivation of Liberty Safeguards' operation. Regional differences in the age of the local populations may account for some of the variation and we will continue to explore the reasons for this. Next year, we plan to explore ways to examine in more detail the 'outliers' among local authorities in their role as supervisory bodies. By 'outliers' we mean local authorities which do not seem to authorise many, or in contrast approve very many Deprivation of Liberty applications.

## Our monitoring activity shows that:

- **People's experiences of the Safeguards are mixed.** We carried out a survey of a number of Independent Mental Capacity Advocate (IMCA) services. This provided some evidence of good practice but also evidence that people are still not always being listened to, or involved in important decisions about their lives, or the lives of a relative or friend. Our case studies in this report show how the Deprivation of Liberty Safeguards system can work well for people.
- **In many care homes and hospitals, little appears to have changed from the situation we described in last year's report. In particular:**

- People subject to the Deprivation of Liberty Safeguards, their families and close friends may not always be involved as they should be. Our evidence suggests that some people cannot properly exercise their legal rights and cannot challenge their detention under the Deprivation of Liberty Safeguards.
- Levels of awareness and understanding of the Deprivation of Liberty Safeguards system still appear to be low. Of the local authorities that responded to our survey, 85% said that hospitals' and care homes' poor understanding of their role and function was a barrier to good practice.
- **Care homes and hospitals are failing to notify us of applications to use the Deprivation of Liberty Safeguards and their outcomes.** Around two-thirds of care homes and hospitals who make applications are failing to notify us of the applications or their outcomes, as required by Health and Social Care Act regulations. This is similar to the previous year. Failure to notify us removes an important element of protection for people subject to the Deprivation of Liberty Safeguards, as well as their families, friends, and the staff and organisations caring for them, by lessening our knowledge of how and where the Deprivation of Liberty Safeguards are being used.
- **Knowledge of the Deprivation of Liberty Safeguards system generally appears to be good among local authorities. Most had appropriate structures and processes in place to operate the system effectively.** This year we continued the work we started last year to explore the activities of 'supervisory bodies' (local authorities and primary care trusts) in the Deprivation of Liberty Safeguards system. We surveyed local authorities and followed up by interviewing a sample of respondents.

When looking at our monitoring information overall, alongside data from the Information Centre, it is difficult to avoid the conclusion that some people in care homes and hospitals may continue to be subject to restrictions (including restraint) without the full protection of the Mental Capacity Act.

## Next steps

### We expect:

- There must be the best possible communication, consultation and sharing of information with the person directly affected by the Deprivation of Liberty Safeguards, their representatives and other close relatives and friends.
- Hospitals and care homes must significantly improve their notification rates to us. Our notification forms can be found on our [website](#).
- Care homes, hospitals and local authorities must work together locally to raise awareness and improve understanding of the Deprivation of Liberty Safeguards and the MCA more widely.

### We recommend:

- That NHS England includes expectations on the effective use of the Deprivation of Liberty Safeguards in the standard contract for providers.

### We encourage:

- IMCA services to monitor their levels of activity around requesting reviews and supporting challenges to the Court of Protection.
- Local authorities who do not robustly monitor the Deprivation of Liberty Safeguards to analyse various aspects of their systems, especially about meeting statutory deadlines and communication with people directly affected.

### We will:

- **Increase our efforts to capture the experience of people who are, or have been, subject to authorisation, and of their families and friends.**

We will do this in two main ways. Firstly we plan to work further with local authorities and IMCAs to identify people who are or have been subject to the Deprivation of Liberty Safeguards, and their relatives or friends, who would be happy to be interviewed about their experiences, and discover as much as we can about their experiences.

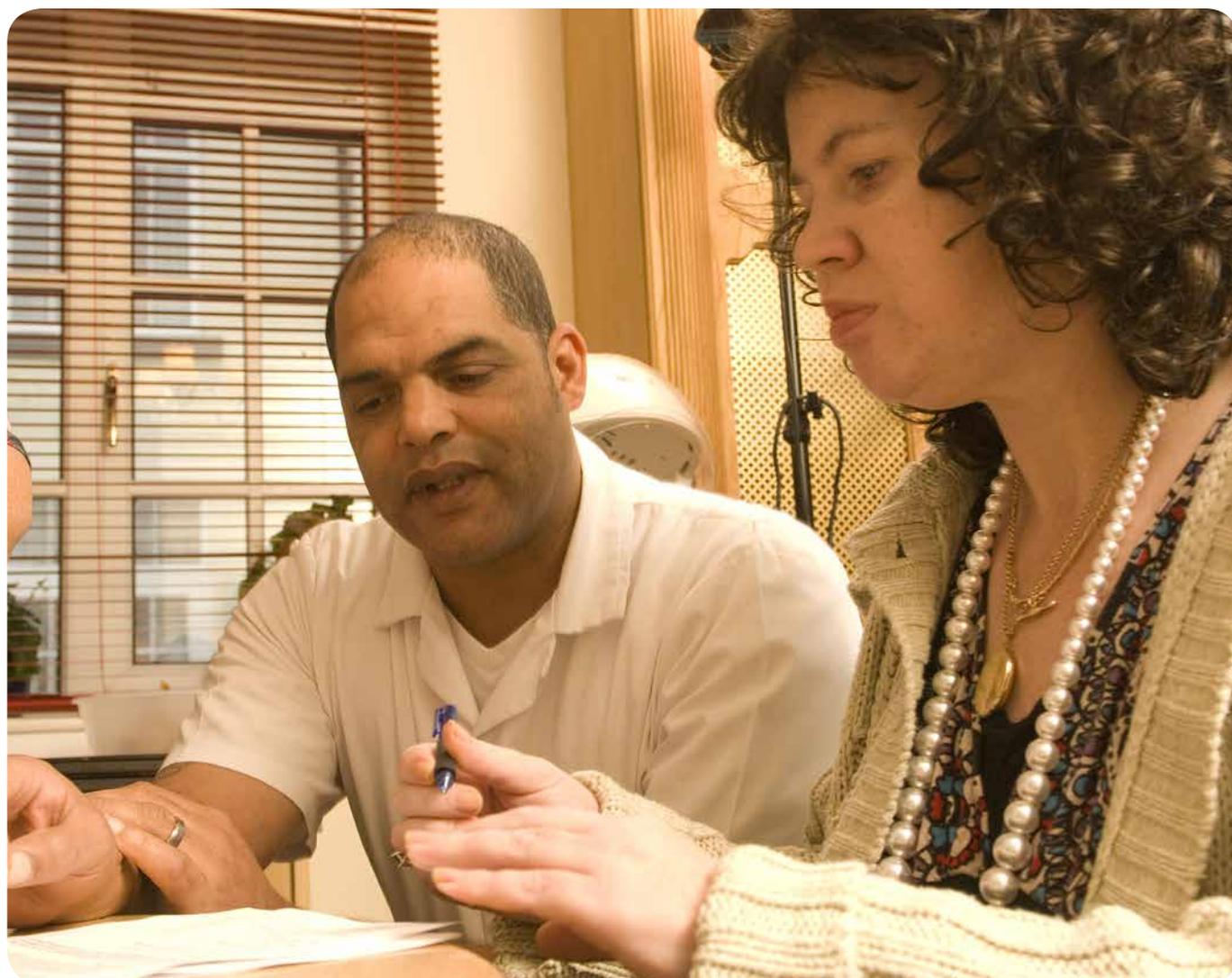
Secondly, building on our work with local authorities and IMCAs, we will particularly look at the situations of people who have been subject to a succession of authorisations over a year or more, who will be identified for us by local authorities and/or the care homes or hospitals where they have been living. We will ask the following questions of the hospitals or care homes, and of the local authorities who are granting these authorisations: Are all possible efforts made to reduce restraint? Are the person's best interests being identified and promoted holistically? Are people in the right settings? Are their rights to challenge the authorisation to the Court of Protection being facilitated and promoted?

- **Make sure the MCA is embedded into the way we operate.** We will continue to improve the knowledge and confidence of our inspectors, and encourage them to support all the services we regulate towards confident, human rights-based MCA compliant practice. As part of this, we will update the materials available both to inspectors and users of our website. We will also weave the MCA into the key lines of enquiry which are being developed as part of our new approach to regulation and inspection for all sectors and, wherever relevant, into the indicators of 'what good looks like'.
- **Continue to build on our collaborative relationships with local authorities, to promote improvements in Mental Capacity Act compliance across the health and social care system.** Building on the success of this year's collaborative work with local authorities, CQC's Chief Executive will write to all directors of adult social care encouraging them to prioritise a continued collaboration with the CQC, with the mutual objective of understanding the impact of the Deprivation of Liberty Safeguards system on people's experience of care. We plan to repeat the survey approach and follow up interviews in next year's programme of monitoring work.
- **Promote understanding of the Deprivation of Liberty Safeguards in care homes and hospitals.** As part of meeting this, in consultation with provider organisations and our external advisory group, we will develop a survey of levels of awareness and understanding of the Deprivation of Liberty Safeguards and of the MCA more widely.

# Introduction

The Deprivation of Liberty Safeguards were introduced in 2009. They are part of the legal framework set out in the Mental Capacity Act 2005 (MCA). The MCA is concerned with protecting and enhancing the human rights of people who lack the capacity to make their own decisions.

Around two million people in England and Wales may lack the capacity to make certain decisions for themselves at some point due to illness, injury or disability. Another six million people will be involved in their care and support, including family, friends and staff working in health and social care.<sup>1</sup>



<sup>1</sup> Ministry of Justice, Mental Capacity Act Bill, Full Impact Assessment, undated.

The aim of the Deprivation of Liberty Safeguards is to protect the human rights of such people in certain settings when the restrictions on their freedom, imposed in their best interests, mean that they are deprived of their liberty.

Although the number of people who are subject to the Deprivation of Liberty Safeguards is relatively small, people who need assessment for them are often among the most vulnerable in society. They include people with severe learning disabilities, people with dementia, and people who have brain injuries and other conditions that affect cognitive functions.

## **Our role in monitoring the Deprivation of Liberty Safeguards**

We have a duty to monitor the operation of the Deprivation of Liberty Safeguards in England. This comes from two sources:

- We have an underpinning duty to protect and promote the rights of people who use health and social care, including people deprived of their liberty, and to make sure that care and treatment is provided in accordance with the MCA where appropriate.
- We have specific and important duties as one of 18 bodies that form part of the UK's National Preventive Mechanism under OPCAT (the United Nations Optional Protocol to the Convention against Torture). This performs the UK's obligations under the treaty to prevent torture and other cruel, inhuman or degrading treatment or punishment.

There are no direct enforcement powers associated with our role in monitoring the Deprivation of Liberty Safeguards. If we find that they are not being used correctly, we can take action under the Health and Social Care Act. A number of the Health and Social Care Act regulations contain references to elements of the MCA including the Deprivation of Liberty Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

## **The context for our monitoring**

In 2013 we set out our vision and direction for CQC in *Raising standards, putting people first, our strategy for 2013 to 2016*.

### In our strategy we promised:

“ We will strengthen our focus around the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) to protect the human rights of some of the most vulnerable people in society, particularly those who have had their freedom restricted by being detained and treated against their will. We are committed to strengthening the protection of people with learning disabilities, whether or not they are detained.”

In our subsequent consultation, *A New Start*, we said that we will ask five key questions of all services – are they safe, effective, caring, responsive to people’s needs and well-led? As we develop our new regulatory model, we plan to embed the MCA into the way we address these five questions. If we find that the Deprivation of Liberty Safeguards are not being used correctly, this will inform our judgments on the quality and safety of that service.

More recently we have published *A fresh start for the regulation and inspection of adult social care* and a signposting statement setting out our new approach to inspecting specialist mental health services. Both of these flag our intention to strengthen our focus on implementation of the MCA as a mechanism for safeguarding people’s rights and promoting good practice.

2012/13 was also a year of very significant change for health services as they prepared themselves for the new, devolved NHS. This was the last year in which primary care trusts (PCTs) existed and could act as supervisory bodies. From April 2013 all supervisory body responsibilities were taken on by local authorities.

### What do the Deprivation of Liberty Safeguards mean to people affected by them?

In previous reports, we tended to concentrate on issues of process in the way the Deprivation of Liberty Safeguards are used, rather than looking at what they actually mean to people affected by them.

Last year’s report signalled a change in this approach, by exploring approaches to understanding the views of people and their relatives, as well as reporting on levels of awareness and understanding among staff. This aligns with the first of the ‘top ten changes’ suggested in order to achieve our new regulatory model, signalled in *A Fresh Start for the Regulation and Inspection of Adult Social Care*, where we recognise the importance of people’s views and experiences.

This year’s report builds on this approach.

There are several groups of people affected by the Deprivation of Liberty Safeguards, including:

- People who lack capacity to consent to being in hospitals and care homes, but who need to be there in their best interests.
- Their families and friends who are directly involved and/or take an active interest in their care and welfare.

- Professionals such as doctors acting as mental health assessors, best interests assessors (BIAs), and community members such as relevant person’s representatives (RPRs) and independent mental capacity advocates (IMCAs), who all have specific roles in relation to the Deprivation of Liberty Safeguards.
- Other health and social care staff in hospitals and care homes (called “managing authorities”) working with people who are subject to the Deprivation of Liberty Safeguards.
- Staff working for local authorities in their role as supervisory bodies with responsibilities for the operation of the Deprivation of Liberty Safeguards.

We are particularly interested in understanding the direct experience of people who use health and social care services, their families and close friends so this report concentrates on them. We have carried out surveys of local authorities and of Independent Mental Capacity Advocates (IMCAs) to find out how the Deprivation of Liberty Safeguards are being used in practice. We have also collected accounts of the impact they have on people’s experience of treatment and care, and the experience of their relatives and close friends. These are illustrated throughout this report, as in the following example.

### Reducing the need for deprivation of liberty



Mr and Mrs A have been married for 66 years. She now uses a wheel-chair and Mr A has early dementia and memory problems. He was admitted for respite care to a care home, where he was thought to have some self-neglect issues. Both of them were adamant before he went there that he should return home shortly. Mr A’s community nurse and social worker highlighted that things had been difficult at home, since Mrs A had seen him as uncooperative rather than forgetful. They feared that there might be adult safeguarding risks if he returned home and suggested making the placement permanent.

Mr A’s GP increased his medication when he was in the care home. During assessments for a requested Deprivation of Liberty Safeguards authorisation, the Best Interests Assessor (BIA) discovered that Mr A was sleepy and withdrawn. The GP agreed to the BIA’s suggestion to reduce Mr A’s medication significantly. Within a few days, he was assessed to have capacity to decide to return home, as he and his wife had continued to request. Concerns among professionals about the risks for him returning home were noted to fall away once he was assessed as having capacity to make this decision, and all concerned worked proactively to put a support package in place.

Sometimes it is reported that the Deprivation of Liberty Safeguards appear to be misused, as in this example where there was no attempt to maximise the person's freedoms and lessen the need for deprivation of liberty:

### Misuse of an authorisation has a negative impact



A middle-aged man with a diagnosis of dementia was placed against his will in a residential care home. A standard authorisation was given because the deprivation of liberty was felt to be in his best interests. An IMCA reported, "The home made no attempt to help him come to terms with the Deprivation of Liberty Safeguards, refusing to take him to his working men's club (only five minutes away by car) where he had served on the committee for many years. He

wanted to go and meet his friends, enjoy a drink and be sociable." Eventually he was found leaving by a ground floor window with his suitcase, though with nowhere to go. The care home said they could no longer 'manage' him.

A best interests decision found him a more suitable place to live, where he was not deprived of his liberty, and he was happy to stay there.

# 01 Patterns of use of the Deprivation of Liberty Safeguards

## Key points

- Use of the Deprivation of Liberty Safeguards overall did not increase greatly during 2012/13, but there were still unexplained regional differences in their use.
- There has been a significant increase in applications for the use of the Deprivation of Liberty Safeguards to protect the rights of older people deprived of their liberty in their best interests. In contrast, there has been a slight fall in the applications relating to people aged 18 to 64.

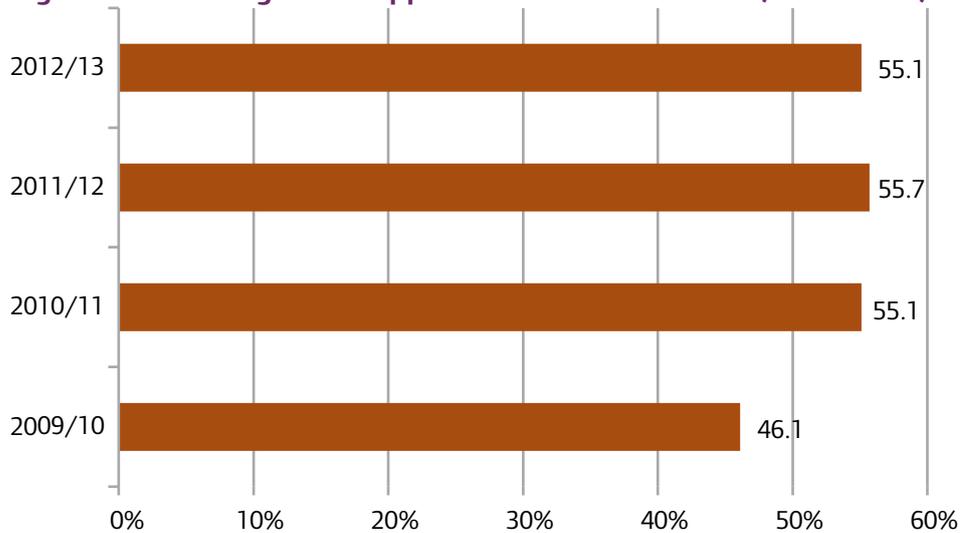


The Health and Social Care Information Centre published its annual report on use of the Deprivation of Liberty Safeguards in 2012/13 in August 2013.<sup>2</sup>

There has been a year-on-year rise in the number of applications since the Deprivation of Liberty Safeguards were introduced, but the rate of increase this year was smaller than previous years. There were 11,887 applications in 2012/13, a 4% increase on the 11,393 applications in 2011/12.

The number of authorisations also rose, although the rate of increase was smaller than in previous years – there were 6,546 authorisations granted, compared to 6,339 in 2011/12.

**Figure 1: Percentage of all applications authorised 2009/10 to 2012/13**



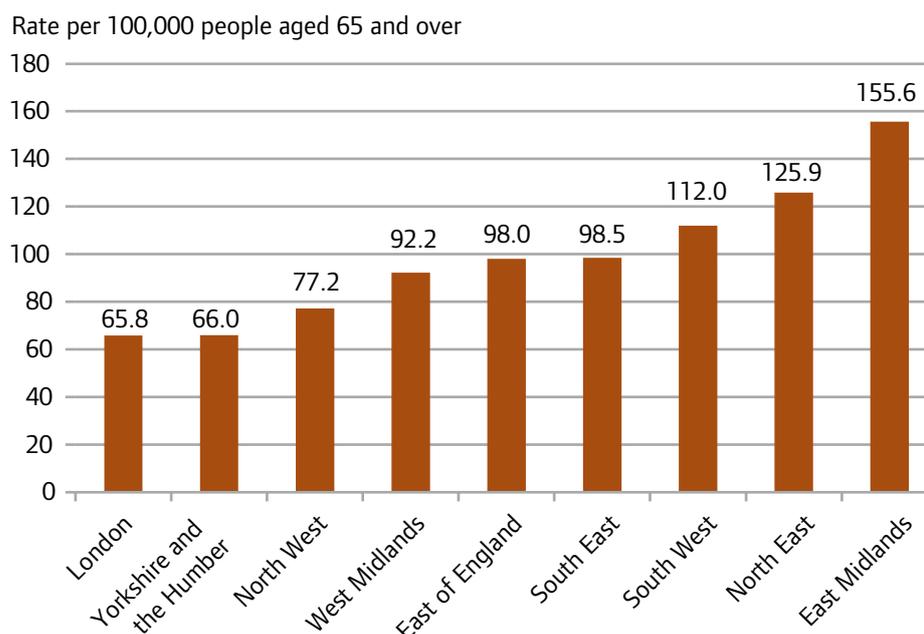
## Regional variation

A source of ongoing concern is the wide variations in application rates by region.

The HSCIC report highlighted the degree of regional variation when looking at the number of applications per adult population – the lowest region was London with 14.1 applications per 100,000 and the highest was East Midlands with 48.6 per 100,000. We found that some of the variation was possibly explained by differences in the demographic profile for each region. Around three quarters of applications concern people aged 65 and over. For this age group, the regional differences were smaller. The lowest rate per 100,000 (London, which has generally a younger population than the average) was 65.8, and the highest (East Midlands) was 155.6 (figure 2).

<sup>2</sup> Health and Social Care Information Centre: *Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) Annual Report 2012/13* (August 2013)

**Figure 2: Deprivation of Liberty Safeguards applications, 2012/13**

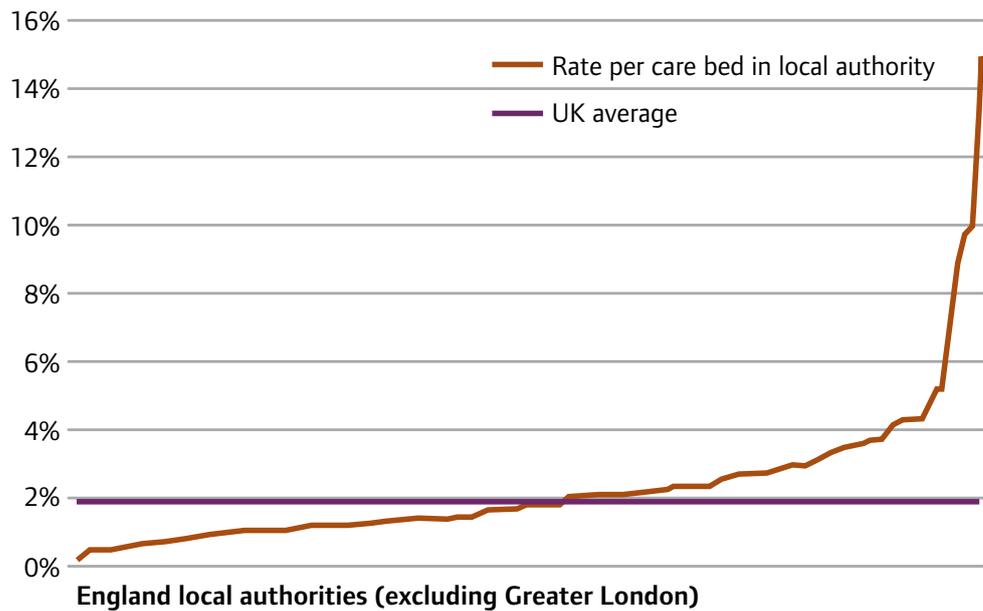


However, the observed differences in applications rates remain unexplained. It is likely that awareness and understanding of the Deprivation of Liberty Safeguards, and of their place in the wider MCA, is still very variable.

Figure 3 further illustrates the variations among local authorities. This compares the number of care home beds in each local authority area with the number of applications from care homes for authorisation under the Deprivation of Liberty Safeguards.<sup>3</sup>

3 Data based on the HSCIC 2012/13 report table 9 (<https://catalogue.ic.nhs.uk/publications/mental-health/legislation/m-c-a-2005-dep-lib-saf-ass-eng-2012-13/m-c-a-2005-dep-lib-saf-ass-eng-2012-13-tab.xls>) and CQC data on number of care beds in each local authority area. Greater London authorities are excluded from this because they are historically more likely to have a greater number of out of area placements, which may skew the rates per bed.

**Figure 3: Applications per care bed in each local authority**



Greater London has been excluded from this graph because we know they use many out of area placements, which might skew the results.

Next year, we plan to explore ways to examine the ‘outliers’ (local authorities which do not seem to receive many applications, or which receive many more than other authorities) in more detail. We will look at whether differences in the local authorities’ management or processes account for the disparity, and assess the significance of the differences.

### Who the Deprivation of Liberty Safeguards apply to

Other data from the Health and Social Care Information Centre showed that the majority of applications, and authorisations granted, relate to older people with dementia living in care homes. Dementia accounted for 53% of all applications, the same as 2011/12. Fifty-nine per cent of these were authorised, again the same as in 2011/12.

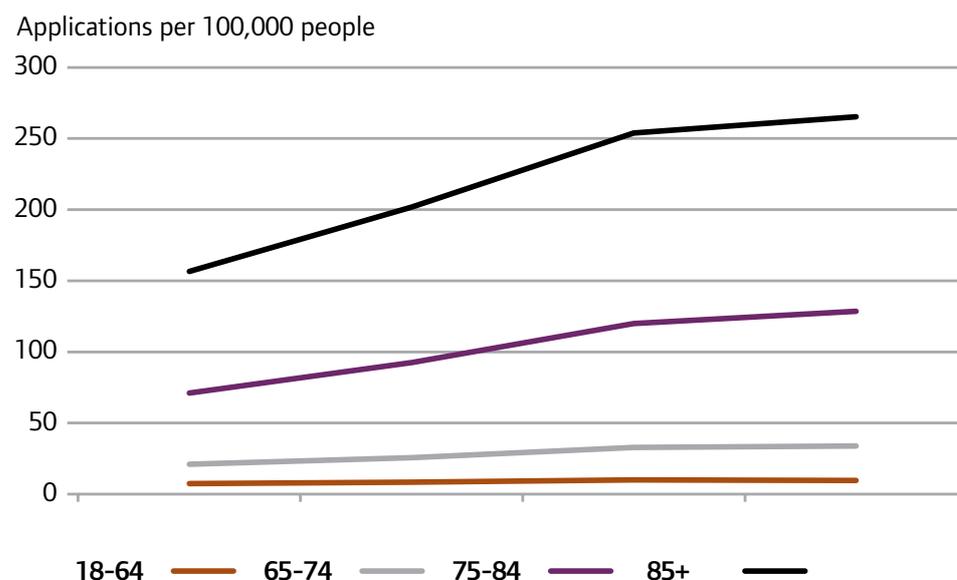
Seventy-three per cent of applications were made on behalf of people aged 65 and over, compared to 71% in 2011/12. In both years, 56% of these were authorised.

In total, 56% of all authorisations were granted for a duration of 0-90 days, compared with 51% in 2011/12.

Local authorities received 71% of all applications (72% in 2011/12), of which 57% resulted in authorisations – the same figure as in 2011/12. In the last year they had responsibilities as supervisory bodies, PCTs authorised 50% of applications made to them (52% in 2011/12).

As shown in figure 4, there has been a sharp increase in the number of applications in the two oldest age bands 75-84 and 85 and over, increasing from 71.2 and 156.6 per 100,000 in 2009/10 to 128.6 and 265.3 per 100,000 in 2012/13 respectively. This contrasts sharply with the 18-65 age group, for which the rate has increased much less over the period and fell slightly last year.

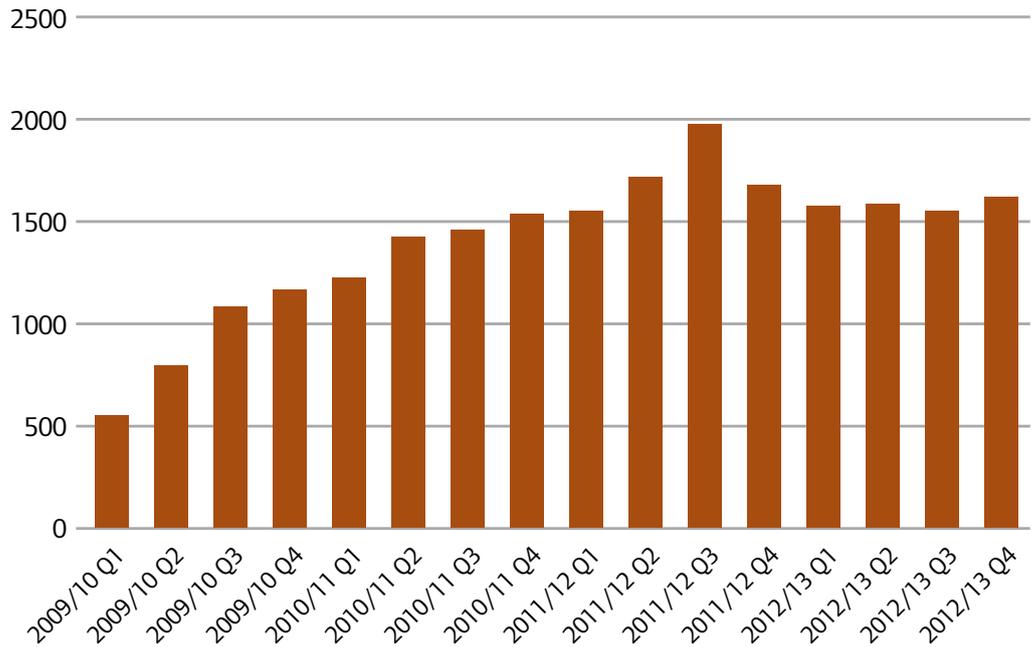
**Figure 4: Applications by age range**



**This sharp increase in use of the Deprivation of Liberty Safeguards to protect the rights of older people who are deprived of their liberty is something that we will continue to monitor, to make sure that the care being provided is in the best interests of these people, and that no less restrictive options can be identified for their care.**

Figure 5 shows how many people were subject to a standard authorisation at the end of each quarter in the last four years. The slight decrease in 2012/13 compared to the previous year might be the result of uncertainty among best interests assessors about how to incorporate ongoing case law into their findings about whether restraint did, or did not, amount to a deprivation of liberty in specific situations.

**Figure 5: Number of people subject to a standard authorisation at quarter end, 2009/10 to 2012/13**



In fairly rare situations, best interests assessors found that a deprivation of liberty was occurring but could not be authorised. This is generally because less restrictive options were available to prevent harm to the person, so the proposal to deprive them of their liberty was not in their best interests as defined in the MCA. The number of such unlawful deprivations of liberty identified through the authorisation assessment process showed a small and statistically insignificant decrease in 2012/13, compared to 2011/12.

There were 93 cases in 2011/12 (1.84% of the total number of applications that were not granted) compared to 88 in 2012/13 (1.64%). It is unlikely however that all incidents of unlawful deprivation of liberty have been identified by this process: after all, in order to apply, the hospital or care home must understand enough about the MCA and the Deprivation of Liberty Safeguards to claim formally that they regard deprivation of liberty as being in the person’s best interests, and proportionate to the risk and seriousness of harm to the person.

**In light of the variable understanding of the MCA, we remain concerned by the possibility that instances of unlawful deprivation of liberty may not be recognised by providers or commissioners.** Consequently, these cases would not be referred to the supervisory body for assessment, nor to the Court of Protection, and there may be no informed scrutiny or attempt to prevent possible deprivation of liberty.

# 02 Monitoring the use of the Deprivation of Liberty Safeguards through inspection of care homes and hospitals

## Key points

- To carry out our fundamental responsibility to protect and promote the rights of people who use health and social care, it is essential that we monitor how well care homes and hospitals understand when and how to use the Deprivation of Liberty Safeguards.
- As in previous years, a majority of care homes and hospitals fail to comply with their statutory requirement to notify us of applications to use the Deprivation of Liberty Safeguards, and their outcomes. This makes it harder for our inspectors to identify people subject to application or authorisation for inclusion in pathway tracking.
- We expect hospitals and care homes to notify all outcomes of Deprivation of Liberty Safeguards applications to CQC.
- We remind all care homes and hospitals of the requirement to work with people who may lack capacity to consent within the framework of the MCA, and in particular to make every effort to minimise restraint and restrictions on liberty.
- We are working to improve the knowledge and confidence of our staff with regard to the Deprivation of Liberty Safeguards and the wider MCA.



In this chapter we provide information on statutory notifications sent to us by care homes and hospitals about use of the Deprivation of Liberty Safeguards. We describe what we are doing and have done, to strengthen the relevant knowledge of our inspectors. We also give illustrative examples from our inspectors.

Our inspectors monitor the operation of the Deprivation of Liberty Safeguards as part of their broader inspection visits to care homes and hospitals. When monitoring their use, our inspectors look first to see if a request for authorisation has been made. This provides evidence of good practice as staff have identified a risk of depriving someone of their liberty and taken the necessary action to protect the rights of that individual. If the Safeguards are used, we check that hospitals and care homes understand how they work. For example, we check that before their use all efforts have been made to reduce the deprivation of liberty.

We are concerned, on the basis of data about variation across supervisory bodies, that there may be people who are not receiving the protection of the Deprivation of Liberty Safeguards when they should be because the hospital or care home has not sought authorisation or tried to find ways to remove any deprivation of liberty.

## Notification issues

Regulation 18 of the Health and Social Care Act 2008 states that all care homes and hospitals must notify CQC of each Deprivation of Liberty Safeguard application and its outcome. However, the number of notifications made to us by hospitals and care homes differ significantly from the number of notifications made by supervisory bodies (local authorities and PCTs) to the Health and Social Care Information Centre (HSCIC). This difference is shown in table 1 for 2012/13.

**Table 1**

	Authorisation requests received by supervisory bodies and notified to HSCIC	Notifications received by CQC
Local authorities	8,464	2,977
Primary care trusts	3,423	1,460
<b>Total</b>	<b>11,887</b>	<b>4,437</b>

Like last year, notifications to us by care homes and hospitals are about a third of those made to the HSCIC by local authorities. We investigated this issue in one local authority area and found that out of 48 hospitals and care homes, 17 did not submit Deprivation of Liberty Safeguards notifications to us. These 17 settings had made 32 authorisation requests out of a total for that local authority of 105. As reported elsewhere, this may be connected with low levels of awareness and understanding of the MCA and DoLS, or more specifically with their lack of understanding of the requirement to notify us. This information has

been referred to our relevant inspector teams for follow up with the hospitals and care homes concerned.

Under-notification removes an important element of protection for people subject to the Deprivation of Liberty safeguards, as well as their families and friends, and the staff and organisations caring for them. It also obstructs us in our statutory duty to monitor the Deprivation of Liberty Safeguards in order to understand in detail how they are used.

**We expect hospitals and care homes to significantly improve their notification rates to us in 2013/14. To assist them, we are asking our inspectors to check specifically during their visits whether any applications have been made to use the Deprivation of Liberty Safeguards, and if so whether those applications and their outcomes have been notified to us.** Our forms for notification are on our [website](#):

**We also expect providers to implement policies that minimise the use of restrictions and promote the liberty of the individual.** It is essential that hospitals, care homes and local authorities fulfil their statutory duty to explain to people who are subject to the Deprivation of Liberty Safeguards, their representatives, their families and close friends their rights and how to challenge the authorisation. They must also continue to seek less restrictive ways to deliver care and treatment to people who lack capacity to consent to what is proposed in their best interests.

## CQC inspectors and other frontline staff

In last year's report, we committed to improving the knowledge and confidence of our inspectors regarding the MCA, including the Deprivation of Liberty Safeguards.<sup>4</sup>

The following actions have been taken since then to improve staff understanding:

- An e-learning package, setting the Deprivation of Liberty Safeguards within their essential context of the MCA, is available to staff including Registration Assessors and Compliance Inspectors, and is being updated.
- We revised our general MCA guidance to reflect amended regulations (Regulation 18) that require a best interests process to be carried out when people are assessed as lacking capacity to consent to proposed interventions. This was produced as separate editions for our staff and providers.
- All new inspectors receive specific MCA induction training, including the Deprivation of Liberty Safeguards. The content has been significantly expanded on what was previously available.
- Staff with MCA expertise have attended a number of staff events to speak about the MCA over the last 12 months.
- MCA issues and developments are now included as a permanent agenda item in monthly meetings attended by regional leads from across country.

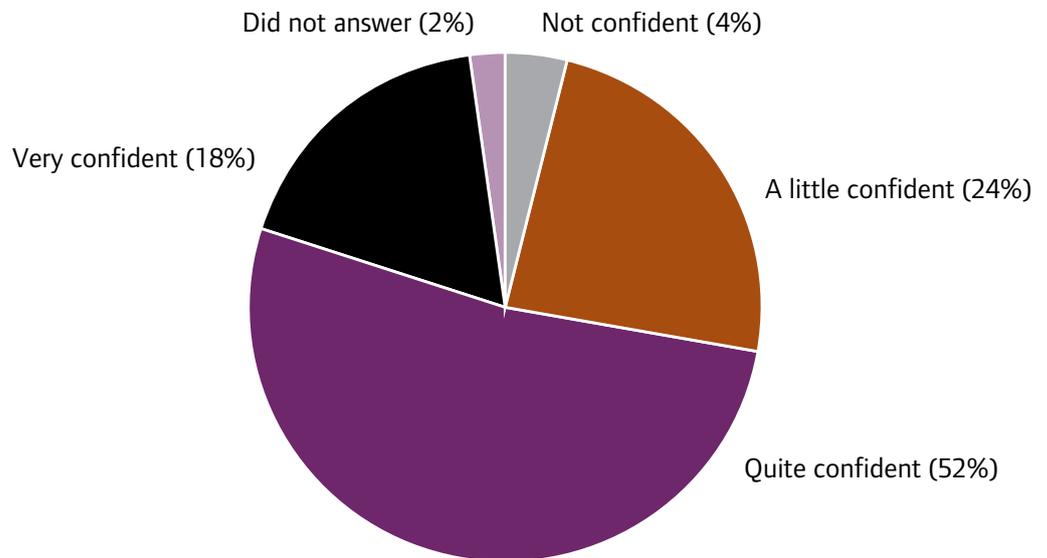
Further work is in progress as part of longer-term initiatives to improve staff understanding. Our human resources team has carried out a Skills Audit

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4 Care Quality Commission: *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12*, 2013

that included a question for frontline operations staff, including compliance inspectors, compliance managers, registration assessors, registration managers and heads of function (figure 6).

**Figure 6: CQC skills audit “How confident are you in your understanding of the duties and responsibilities placed on providers/applicants by the Mental Capacity Act?”**



The largest group surveyed were compliance inspectors with 884 individuals. Respondents included other staff as well as inspectors, but inspectors’ specific answers are statistically the same as those for all front-line staff that appear in figure 6 – and indeed a good understanding of the MCA is essential for all frontline staff. This information feeds in to the following work:

- Wider changes to our training and development packages with the launch of the ‘CQC Academy’ – a new initiative to support learning across our workforce. Discussions are in progress to make sure that the Academy will bring a joined-up approach that appropriately places an understanding of the MCA within the wider changes that are planned to the regulatory model across all sectors.
- We plan to explore with inspectors how to increase their confidence in assessing use of the MCA – for example by creating discussion groups similar to those used by best interests assessors, where practice examples can be used to share learning.
- We will re-assess inspectors’ knowledge and confidence next year and hope to see significant improvements.

### **Our inspectors’ experiences of monitoring the Deprivation of Liberty Safeguards**

This information was collected by asking inspectors for examples of the use of the Deprivation of Liberty Safeguards from their practice.

When care home or hospital settings are chosen for inspection, inspectors are informed of any activity within the Deprivation of Liberty Safeguards, such as an urgent authorisation accompanied by a request for a standard authorisation,

provided that this information has been sent as a notification to us. As previously highlighted, these notifications are not made as often as they should be. Our inspectors are now looking for situations where notifications should have been made, and using their visits to explain their importance as in the following example:

“ *[The inspectors noted that] several requests for authorisation had been made by the home, though nobody was currently subject to authorisation: none of these requests, or their outcomes, had been notified to the CQC. The inspectors discussed this with the manager, and, when they re-visited, improvements had been made to the home’s notification system.* ”

Where notifications have been received, the inspectors select people subject to authorisation as part of their sample for ‘pathway tracking’. The Code of Practice to the Deprivation of Liberty Safeguards explains that CQC’s monitoring is not for the purposes of reviewing the authorisation decision by the supervisory body.<sup>5</sup> The Code also makes it clear that “Monitoring should take place at a time when the monitoring body is visiting the care home or inpatient setting as part of routine operations, not as an exception” (Code, para 11.7).

On an inspection, our inspectors will look for any situations “where they believe deprivation of liberty may be occurring without an authorisation” [and] “notify the supervisory body in the same way as any other third party may do” (Code, para 11.6). Although knowledge and confidence among our inspectors currently varies – an issue being addressed – some are notably expert in this area. However, they are not expected to have the specific expertise in conducting an analysis of whether a specific situation is a deprivation of liberty or not; they should only be bringing to the attention of managing authorities and supervisory bodies those situations they think should be subjected to expert assessment within the Deprivation of Liberty Safeguards.

Another function of inspection where there has been an authorisation is to check that all attempts to reduce the level of restriction, so that the person is no longer deprived of their liberty, are continuing.

Examples noted by inspectors include:

“ *One person living at the home had been subject to the [Deprivation of Liberty] Safeguards. The home had followed the proper process to ensure that the decision to deprive someone of his liberty was properly assessed by the local authority. The person was taken off the Safeguards as soon as practicable, when the restrictions could be lessened.* ”

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<sup>5</sup> Ministry of Justice *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental capacity Act 2005 Code of Practice* London, TSO, 2008, 11.3-11.6

It is important that inspectors understand the context of requests for authorisation, as noted by an inspector:

“*During the inspection a best interests assessor arrived. The home had acted correctly in requesting authorisation for a complex situation where an elderly lady was determined to return home, but her elderly husband was adamant she could not be safely cared for at home. The assessment process was able to examine all facets of this situation to find the best way to protect this lady’s rights.*”

Our inspectors should understand the need to identify when the managing authority is correctly carrying out its roles and duties under the Deprivation of Liberty Safeguards, which include monitoring whether the Representative appointed under this framework is visiting and carrying out their own protective role. In one case,

“*[The inspector noticed that] the representative appointed for someone subject to the [Deprivation of Liberty] Safeguards had not visited the person. The care home thought it no longer necessary to deprive this person of her liberty, and had requested the supervisory body to review to lift the authorisation, but the inspector took this opportunity to discuss with the manager of the home their responsibility to tell the supervisory body if a representative appointed under the Safeguards does not visit, since they are appointed to monitor the authorisation to protect the person’s rights.*”

Inspectors also provided examples of finding lack of MCA-compliant practice: these included failures to consider decision-specific and time-specific capacity, and failure to make best interests decisions as laid out in the MCA.

**We intend to build on the experience of inspectors, using the transformed inspection processes, to gain a clearer picture of how the Deprivation of Liberty Safeguards are being used in the hospitals and care homes we inspect. To learn all we can about the experience of the person deprived of their liberty and their relatives or friends, we will encourage inspectors to hear and report the voice of the detained person, their representative, and other supporters. We will also encourage inspections to be used as ways to improve MCA practice whenever appropriate, for example by providing links to information and tools. We provide in Appendix B some links to information useful for professionals, advocates, people affected by the Deprivation of Liberty Safeguards and their supporters.**

## The Deprivation of Liberty Safeguards – part of achieving good outcomes



Miss G is an adult with learning difficulties who came to the attention of the local authority Adult Safeguarding team because she alleged her mother (and carer) was physically and financially abusing her. The local authority moved her to a care home in her best interests. A subsequent Deprivation of Liberty Safeguards best interests assessment identified the need to take this case

to the Court of Protection, in light of case law. The court upheld the decision that G had the right to refuse to see her mother if she chose. G has learnt to use buses, has gone to college, and gained other life skills since living away from her mother. Her increasing autonomy means that her quality of life is greatly increased; she is not deprived of her liberty.

## The Deprivation of Liberty Safeguards – enabling good care and treatment



A patient in hospital was very confused and needed to stay there for further treatment following an accident. His girlfriend was afraid of him because a brain injury sustained in the accident had changed his behaviour. The standard authorisation enabled the ward to

keep him safe and to give him the treatment he needed. It supported the relationship with his girlfriend to continue because she felt safer, and more confident about their future relationship, knowing he was receiving treatment.

# 03 Monitoring of supervisory bodies

## Key points

- We are pleased to have strengthened our collaborative relationship with supervisory bodies, and hope to build on this to improve our shared understanding of the operation of the Deprivation of Liberty Safeguards.
- There appears a wide range of practice with regard to extending urgent authorisations. We encourage local authorities to ensure that this practice is kept to a minimum.
- Very few of the reviews that happen are undertaken at the request of people subject to an authorisation or their representatives. We encourage local authorities and IMCAs to support these people to request reviews where appropriate.



A key commitment that we made in last year's report was to develop our work with local authorities in their role as 'supervisory bodies'. A supervisory body will receive an application under the Deprivation of Liberty Safeguards, commission an assessment and then either grant or decline an authorisation. In order to achieve this we said that we would develop our methodology for gathering information from local authorities.

In last year's report we described the findings from several interviews we carried out with a small number of local authorities.

## Survey

This year we gathered information from both a survey of local authority supervisory bodies and semi-structured interviews. This chapter uses the findings from that process to address two key questions:

- What can we learn about the experience people have of the Deprivation of Liberty Safeguards system, particularly people who lack capacity, their families and close friends?
- Are the correct processes being followed when applications and authorisations are being made? This is important because where they are not being followed this may indicate unlawful activity where people's legal and human rights are not being respected.

Where appropriate we draw comparisons with what we reported last year but because the sample last year was very small, we exercise caution in inferring too much from this.

With the support of the Association of Directors of Adult Social Services (ADASS), an online survey was launched in June 2013 and 118 of the 152 local authorities invited to complete it submitted responses. **We are most grateful to the local authorities who submitted a response, and look forward to working together in the future to understand the range of ways local authorities carry out the supervisory body role within the Deprivation of Liberty Safeguards.**

The survey consisted of 36 questions, a mixture of quantitative and qualitative questions. The question topics ranged from local authority information, to staffing and specific policies. The following areas were covered:

- Organisation of the Deprivation of Liberty Safeguards function
- Assessors
- Independent Mental Health Capacity Advocates (IMCAs)
- Authorising signatories
- Key data
- External peer group support
- Quality and scrutiny arrangements
- Engaging with relevant persons and their representatives
- Equivalent assessments
- Ordinary residence
- Managing authorities

- Barriers to good practice
- Follow-up structured interview.

Semi-structured interviews were carried out with representatives from 20 local authorities who had volunteered via the online survey and were selected to make sure different types of local authorities were represented from around the country. The case studies are taken from examples given by interview respondents.

## People's experiences of the Deprivation of Liberty Safeguards system

The online survey was completed by staff working for local authorities so some caution needs to be exercised about what the findings may tell us about the experience of people directly affected by the Deprivation of Liberty Safeguards system, including their families and close friends. Nevertheless they do give some important indications of what these experiences may be. In particular, the adherence to the regulatory framework by each supervisory body, including the time-scales for completing requests for standard authorisations, highlights the importance placed by each supervisory body on the person's rights to have the process carried out with due care. We do not currently have evidence on how many reviews lead to changes to, or termination, of authorisations but this might indicate recognition of a person's right to a fresh and formal look at the authorisation. We plan to explore this further with local authorities.

### Contact with the relevant person and their representative

Contact with the 'relevant person' (the person who is being assessed for, or subject to authorisation granted under the Deprivation of Liberty Safeguards) and their representative (appointed whenever an authorisation is granted) is clearly central to the person's experience of the Safeguards, as well as the experience of their families and close friends. Over 80% of local authorities indicated that they did this after an application had been authorised, mainly through direct contact between staff and the representative or by written information. However, 17 local authorities indicated that they did not maintain contact after initial contact.

It is possible that the questions in this area were sometimes misinterpreted, since the local authority appoints the relevant person's representative so must have some contact, and the forms prompt the sharing of information with them, including copies of the assessments.

Further examples of good practice beyond initial contact include:

- Full, pro-active involvement by the assessors of relatives in the assessment of the person's application, and in deciding what is in the person's best interests
- Family carers consultation event to get feedback on their experience of the Deprivation of Liberty Safeguards, and discover what further information/support they needed or would have found of benefit
- Accessible, easy read information being made available to the person and their representative to explain the Deprivation of Liberty Safeguards system

- Additional funding arranged for one-to-one support for someone to enable contact with friends and outings into the community, rather than physical restraint, after deprivation of liberty was identified but not authorised.
- Successful use of conditions on authorisations, after discussion with relatives, such as making sure the person is taken out regularly.

## Listening to the person's representative



T was accommodated in an acute hospital and ready for discharge. T had been cared for previously by his wife, who did not want to have a hoist in their home to assist T to transfer as she said it upset T and was unnecessary. The hospital made an application for an authorisation,

to prevent discharge. This was not authorised, which prompted urgent discussions regarding the balance of risks against T's best interests. This led to T being discharged home to be with his wife.

## Independent Mental Capacity Advocates (IMCAs)

Local authorities are required by law to instruct an IMCA to be part of the Deprivation of Liberty Safeguards assessment process when the person has no family or friends who can be consulted as part of the assessments. In addition, they can offer IMCA support to anyone subject to authorisation and to unpaid representatives when they feel the person or representative need support to exercise their rights, such as their right to challenge the authorisation.

Eighty-seven local authorities offered IMCAs to the relevant person and allocated an IMCA on request. Seven local authorities indicated that they always allocated an IMCA to the relevant person, in a way that seems more pro-active than simply offering this service. It appeared that all local authorities offered an IMCA to an unpaid 'relevant person's representative' such as a close relative, friend or unpaid carer.

IMCAs perform a vital role in helping the people subject to authorisation and their representatives to understand the application and authorisation process, helping them to communicate their views, and if the person or their representative wishes it, triggering a review of the Deprivation of Liberty Safeguards or challenge to the Court of Protection. It was encouraging that local authorities, in line with Department of Health guidance, made sure that an IMCA was always available whenever the person's representative was unpaid. However, the interviews also revealed that some local authorities did not appear actively to support or promote IMCAs in their potential role to enable a person to challenge an authorisation to the Court of Protection.



### Good practice example:

- Regular meetings between local authorities (commissioners and professionals) and IMCAs to explore any practice issues

## Extending urgent authorisations

Care homes and hospitals ('managing authorities') have the power to give themselves an urgent authorisation allowing them to detain someone who lacks capacity for up to seven days, in order to provide necessary care or treatment in their best interests. These should only be made in situations where it is expected that the person will be subject to a standard authorisation under the Deprivation of Liberty Safeguards (given by the local authority, after exhaustive assessments) after the seven day period, and copies of urgent authorisations must be sent to the supervisory body accompanied by a request for a standard authorisation, in time to allow the supervisory body to arrange and carry out all the assessments to decide whether or not to grant a standard authorisation. The urgent authorisation can only be extended in exceptional circumstances, and only for a maximum of a further seven days.

There were 720 occasions reported in the survey, by 83 local authorities, of an urgent authorisation being extended (13.4% of the total number of urgent authorisation request, which was the same as the previous year). One local authority used the power 156 times.

For the individuals involved each extension means that they were detained for more than seven days without the full protection of the assessment and authorisation processes of the Deprivation of Liberty Safeguards. This is a significant proportion of the total number of applications over the year and could potentially cause confusion or distress for the individuals involved, as well as any families or close friends.

**We expect local authorities to keep this under review and to make sure that any extensions to the deadlines are kept to a minimum. We will explore the variations in practice among local authorities in the future.**

## Reviews

There were 917 authorisation review requests reported by 84 local authorities. Two local authorities reported over 100 each. Of these, 98.9% resulted in a review being undertaken.

Reviews can be an important way for the relevant person, or their representative, to ask the supervisory body to reconsider the authorisation by carrying out new assessments.

However, this analysis did not take explore in sufficient detail the different uses to which reviews are used. For example, all authorisations which are ended (as no longer necessary, or because the person has moved) need to be formally terminated through the use of the review process by the supervisory body.

Almost two thirds of the reviews resulted in an end to an authorisation, but we do not know how many of these were 'formal reviews' with the sole intention of closing an authorisation which was no longer necessary. The high numbers reported may relate to authorities with a large number of authorisations, many of which will have reached the end of their time-period and needed reviewing in order to close.

Other reviews reported, which led to amended timescales or conditions, are likely to have been checks of authorisations to make sure that the conditions and requirements were still relevant in reducing the need for the deprivation of liberty.

Fewer than 10% of the reviews were done as a result of a request from the relevant person, their representative, or an IMCA. **This is a low proportion, and while reasons for it undoubtedly vary, it would be good practice, particularly for longer periods of authorisation, for a supervisory body to decide to carry out a review if they think it might be necessary and to be assured that it is easy for the person subject to authorisation (or their representative) to request a review whenever they want one.**

Most review requests were from the managing authority (care home or hospital) or came about through the supervisory body deciding itself to carry out a review. These are often interchangeable, since some supervisory bodies ask the managing authority to request a review when, for example, the person has left that care home or hospital while others start the review process without a formal review request when they are told less formally that the situation has changed.

**Any future exploration of the use of the review process within the Deprivation of Liberty Safeguards will need to take account of the varied ways reviews are used.**

## Reviews in action



S moved from the south coast with his wife to Yorkshire. S was then widowed, and developed dementia. Relatives in Yorkshire persuaded him to move to a care home near them, but he did not like it or settle. He was placed under a Deprivation of Liberty Safeguards authorisation. At the same time S's daughter made contact and wanted to rebuild their relationship. The daughter lived in the south. The Deprivation of

Liberty Safeguards review process resulted in S moving to a care home on the south coast where his daughter could more easily stay in contact. S was much happier with his surroundings and environment. A new authorisation was in place initially when he moved to the care home, but in time and following a further review this was removed as no longer necessary.

## Referrals to the Court of Protection

Respondents reported a total of 125 applications made to the Court of Protection either by the person themselves, their representative, or the local authority – on average, more than two a week from the sample completing the survey. The majority of these (79 applications) were made by local authorities (39 in total, of which one local authority made nine applications) and 16 applications were made by the person themselves. The right to bring a challenge to the Court of Protection is a fundamental protection for the person within the Safeguards system, and although this is a snapshot and gives no clear evidence about which cases should be referred, it is good to hear that these challenges are being made.

The interviews with local authorities revealed a range of reasons for applying to the Court including intractable disagreements between local authorities and relatives, and situations where the proposed restrictions were considered to be particularly onerous. Two thirds of those interviewed made arrangements on a case by case basis rather than having a pre-defined process for escalating deprivation of liberty situations to the Court. We can understand why some local authorities may choose to have a pre-defined escalation process for making applications to the Court (including built-in options for lower level mediation, which is a valuable process). However, caution should be exercised to make sure the process does not become too rigid in how local authorities respond to particular cases.



### Good practice example:

- A self-funded person would have been at great risk of having her rights ignored before the Deprivation of Liberty Safeguards which highlighted her situation. She had been placed in a care home from hospital, against her wishes, and was assisted by the local authority to challenge a subsequent authorisation under the Deprivation of Liberty Safeguards to the Court of Protection, on the grounds that it was not in her best interests. The judge decided that she did require residential care, but suggested she be helped to find a more suitable care setting (for her, one with a large garden where she could walk), and where her trust-fund could be used to provide extra staff to take her out.

## The Deprivation of Liberty Safeguards process

### Location of staff

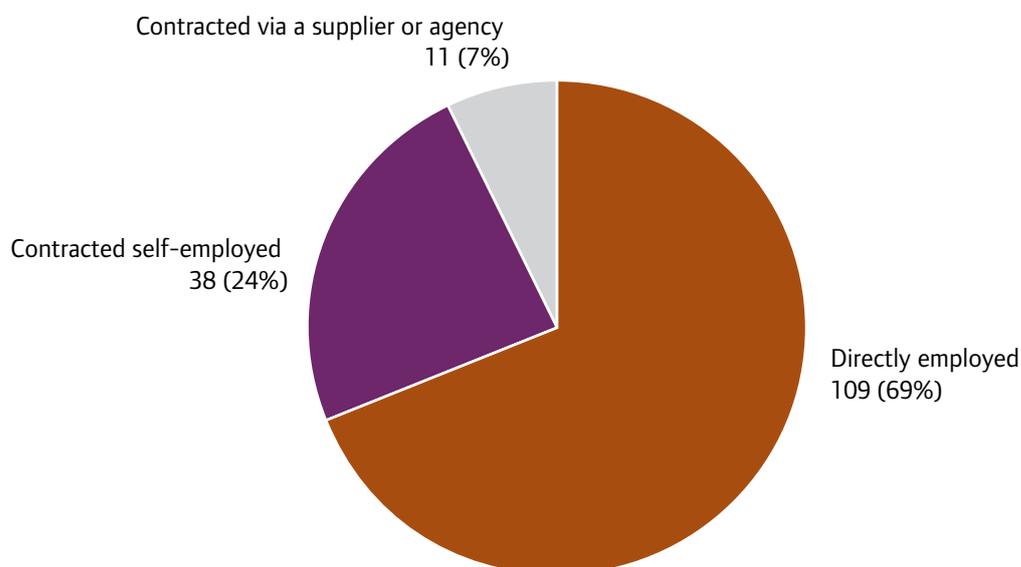
As was the case last year, around three quarters of supervisory body staff were part of a section or team in the local authority that had responsibility for adult safeguarding. Of those that were co-located, most described separate management arrangements and other systemic ways of keeping the work separate. Professional diligence, rigour, understanding of the supervisory body role, knowledge of the MCA and human rights more widely were also cited as important levers to ensure independence for the exercise of the supervisory body functions.

### Staff availability, monitoring and quality assurance

Assessments for authorisations are carried by mental health assessors (doctors with psychiatric expertise) and best interest assessors, (nurses, occupational therapists, social workers or psychologists). All assessors have had specific additional training, and annual refresher training, for their roles under the Deprivation of Liberty Safeguards. For the law to be correctly followed it is important that there are enough assessors and that they have relevant knowledge and experience of the conditions or illnesses that most commonly lead to applications for deprivation of liberty authorisations. Therefore, a supervisory body should have access to assessors with experience of working with, for example, learning disabilities or older people with dementia, or

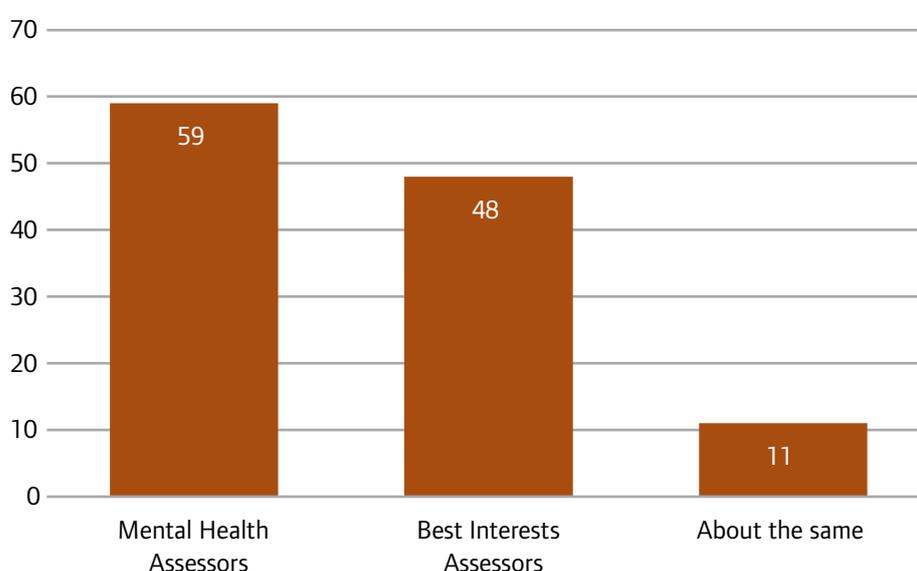
neurological conditions and acquired brain injury. There is a range of practice developing regarding where best interests assessors come from, see figure 7. We do not know whether supervisory bodies are able to monitor and improve assessors' practice equally well where they do not directly employ them, but encourage them to ensure that they can do this.

**Figure 7: Where do supervisory bodies get their best interests assessors?**



Three quarters of local authorities reported having the right number of assessors but it was concerning that 27 local authorities said they had insufficient best interests assessors (BIAs) and 29 said they didn't have enough mental health assessors. Having insufficient numbers of assessors is concerning because it may mean that assessments are delayed and that people could be subject to deprivation of liberty for longer than is acceptable without being authorised by the agreed process of the Deprivation of Liberty Safeguards.

**Figure 8: Who undertakes your supervisory body's mental capacity assessments?**



The assessments of mental capacity within the Deprivation of Liberty Safeguards process can be carried out by both types of assessor, and practice varies as shown in figure 8. We are not aware of differences in outcome between the models.

Local authorities reported a variety of ways in which they monitor and quality assure the assessments that are carried out, the most common ways being activity reporting, checking timescales and deadlines for applications and assessments, staff training, development, supervision and management, regular liaison and governance arrangements. Three-quarters of the respondents regularly analyse Deprivation of Liberty Safeguards activity data and over half had some form of senior level scrutiny. A number of local authorities reported several methods of providing peer support such as regional DoLS network meetings and other forms of contact with neighbouring local authorities.

**Given the high profile of the Deprivation of Liberty Safeguards and the great significance for individuals who are subject to authorised deprivation of liberty, we would expect local authorities to regularly review relevant activity at a senior level.**



#### Good practice examples:

- A quality assurance team developed standards to assess whether the MCA principles are embedded in care planning.
- A regional Deprivation of Liberty Safeguards leads' network where information on numbers and types of referrals are discussed, together with discussion of difficult or novel situations.
- Best interest assessor forums, encouraging BIAs to attend by managing workloads
- Having agreements with neighbouring local authorities to use best interests assessors from elsewhere, for example, if the person was in a local authority managed home, such arrangement would be essential as a best interests assessor employed by the local authority is forbidden to carry out assessments if that local authority is also the service provider.
- Quarterly reports to MCA/Deprivation of Liberty Safeguards committees or multi-agency local networks, to oversee and analyse activity, numbers and deadlines.
- Independent reviews of Deprivation of Liberty Safeguards activity.

#### Authorising signatories

The average number of people who could sign an authorisation was four per local authority. 83% of these also had responsibilities for commissioning and/or managing care services, including residential care. Eleven local authorities said they provided no training to people who could sign an authorisation and a further 33 provided half a day's training or less. Seventy-nine local authorities supported their signatories with legal briefings and 29 provided one-to-one supervision for this role.

It is positive that most local authorities recognise the importance of this role and provided appropriate support. However, given the complexity of the Safeguards

system and the ongoing developments in case law we would expect all local authorities to make sure their signatories have access to appropriate training so they can fulfil their role with up-to-date knowledge.

This is also important because most local authorities reported a reliance on scrutiny and quality checks by signatories as methods to review assessors' use of evidence to support their judgements and recommendations. Thirty-six respondents had experience of authorisers asking assessors to provide further evidence to bear out their conclusions. Furthermore, training and support can also be used to make sure that signatories understand the potential conflict of interest if they are also responsible for commissioning or managing services, and how to handle this appropriately.



### Good practice examples:

- Applying lessons learned from the Stephen Neary case –making sure the authoriser is not a commissioner responsible for the service where the person is living.
- Making sure the authoriser is not also responsible for agreeing funding for the person.

## Authoriser identifies inappropriate placement



V was placed in a hospice and there had already been a couple of short authorisations while he was there. V had been thought to be nearing end of life but following admission the initial prognosis was revised due to his improved health. The authoriser challenged the continued placement of V at the hospice, highlighting his need to move elsewhere more appropriate to his needs. The authoriser was most uneasy about signing a further authorisation to keep V deprived of his liberty in the hospice, and told the relevant care manager personally that V was no longer in

the right place. The senior practitioner involved commented that the authorisers are often in a position to move things forward quickly, as in this case, where a more appropriate placement was found quickly and V was moved.

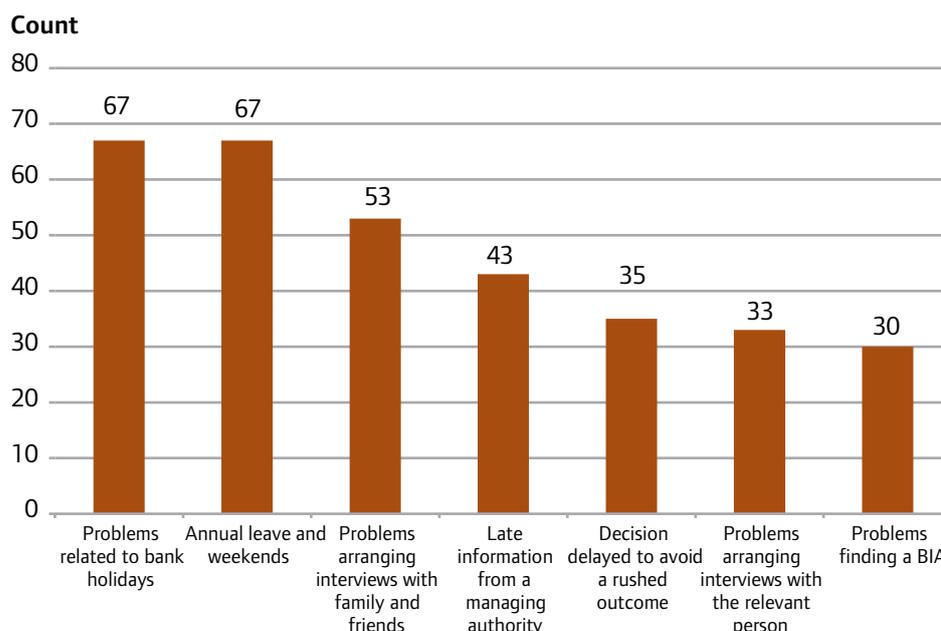
Following the move, he was no longer identified as deprived of his liberty. S was much happier with his surroundings and environment. A new authorisation was in place initially when he moved to the care home, but in time and following a further review this was removed as no longer necessary.

## Meeting statutory deadlines

Although the reported number of delays in processing stand-alone, standard authorisation requests were small and only reported by 12 local authorities, it should be remembered that it is unlawful for the supervisory body to take longer than 21 days from receiving the request to completing the assessments and either authorising the deprivation of liberty or refusing to grant an authorisation.

As reported above, delays in processing standard authorisation requests accompanied by an urgent authorisation (where the deadline reduces to seven days) were more common and 11 local authorities reported delays in over 20% of these requests. The most common reasons for delays were similar to the previous year: problems related to bank holidays, staff leave, weekends, arranging interviews with family and close friends, and late information from a hospital or care home (figure 9).

**Figure 9: Main issues in meeting statutory deadlines**



While we understand that delays may occur unexpectedly in what is often a reactive service, we would expect local authorities that regularly experience delays to review their systems and structures for the Deprivation of Liberty Safeguards to try and identify ways of reducing these delays so that they do not rely wrongly on their ability to extend an urgent authorisation. They must be mindful that

“It is for the supervisory body to decide what constitutes an “exceptional reason”, but because of the seriousness of the issues involved, the supervisory body’s decision must be soundly based and defensible. It would not, for example, be appropriate to use staffing shortages as a reason to extend an urgent authorisation.’ (DoLS Code of Practice, 6.24)



#### Good practice example:

- Having agreements with neighbouring local authorities so they can call on best interests assessors from elsewhere if there is an unexpected surge of requests accompanied by urgent authorisations.

#### Equivalent assessments

When carrying out assessments for the Deprivation of Liberty Safeguards it is acceptable to use ‘equivalent assessments’ in order to gather some of the relevant information, such as an assessment under the Mental Health Act.

Apart from the age assessment, an equivalent assessment used for this purpose must have been carried out within the previous 12 months. No local authority reported using equivalent assessments older than 12 months and 27% reported either always commissioning new assessments or only using assessments up to three months old. Particularly in the case of mental capacity assessments, which must assess a person's capacity to make a specific decision at the time it needs to be made, and the mental health assessment, which confirms the presence of a current mental disorder, we would expect supervisory bodies to exercise great caution and judgement over using older equivalent assessments.

## Ordinary residence

Ordinary residence refers to the process of deciding which local authority has responsibility for receiving an application and authorising the Deprivation of Liberty Safeguards for an individual. This can become complicated if the person has no fixed residence, or a person is in a care home or hospital outside the local authority area where they normally live, or where the person is also in receipt of Section 117 Mental Health Act aftercare where different rules apply. A third of local authorities surveyed, reported that some hospitals and care homes didn't understand the criteria for ordinary residence when making applications and a quarter reported problems where people had been placed outside the area the local authority covered. These problems are potentially of concern because they may result in assessments and authorisations being delayed, meaning that individuals may be detained unlawfully for unacceptably long periods of time.

Department of Health guidance on ordinary residence encourages local authorities, hospitals and care homes to make sure key staff are clear about the ordinary residence criteria; in addition, supervisory bodies are warned that a dispute over ordinary residence should not delay assessments for the Deprivation of Liberty Safeguards, and that the local authority receiving the request should start the assessment process even if they are at the same time exploring which authority has responsibility for this<sup>6</sup>.

## Support from supervisory bodies to hospitals and care homes

Hospitals and care homes have a responsibility for making sure that key staff have the correct information about the Deprivation of Liberty Safeguards and their place in the wider MCA. This is so that they know when to make applications for authorisations and what to do when someone they are treating or caring for is, or might be, subject to the Safeguards. Local authority supervisory bodies play a key collaborative role in helping to provide this information. Survey respondents reported that they do this through a variety of methods, the most common being providing advice about potential referrals, offering training (often for no charge) and telephone support lines.

**Local authorities might consider how to survey their local managing authorities, to discover whether the support offered is experienced as the most helpful: a collaborative dialogue between the local authorities and providers is to be encouraged.**

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6 Department of Health Deprivation of Liberty Safeguards Code of Practice (London) 2008 3.3 footnote 8.



### Good practice examples:

- MCA helplines and clear web-based information.
- Regular e-bulletins.
- Provider forums where the MCA and the Deprivation of Liberty Safeguards are regularly discussed
- Focused training on care homes and hospitals where monitoring data shows low activity.
- Commissioning contracts which include knowledge requirements around the MCA and the Deprivation of Liberty Safeguards.
- Audits to check hospital staff knowledge of the MCA, including the Deprivation of Liberty Safeguards, with follow up workplace-based information provided.
- ‘Train the trainer’ programmes for hospital and care home staff so MCA and Deprivation of Liberty Safeguards training can be run in-house.
- Placing the Deprivation of Liberty Safeguards clearly in terms of a personalisation and human rights context when training, to enable them to be viewed more positively.

### Improving awareness and understanding in hospitals and care homes



Following training by the local authority, a psychiatric hospital increased the number of applications for authorisation under the Deprivation of Liberty Safeguards for people who were not detained under the Mental Health Act, as their care and treatment was not distinctly different from that of detained patients. Work

then done by the supervisory body with the NHS trust and service commissioners, helping to increase understanding of care planning within the MCA, resulted in better care planning for these individuals and greater access to the community, lessening the restrictions placed on them. This resulted in a reduction in applications.

### Improving awareness and understanding in hospitals and care homes



The local authority Deprivation of Liberty Safeguards supervisory body lead uses data to identify additional needs for training and support in specific managing authorities. She also attends quarterly homes managers’ meeting as a route to awareness raising and has used this to facilitate discussion on the CQC Deprivation of Liberty Safeguards monitoring reports. She

is also facilitating the development of an MCA-compliant restraint policy to be agreed and used by local care homes.

She emphasises the importance of values in terms of personalisation and rights within engagement with hospitals and care home and believes this has contributed to the Safeguards being better understood and viewed more positively.

## Transfer of supervisory body responsibilities for hospitals

2012/13 was the last year that primary care trusts existed and had responsibilities as local authorities for people in hospitals. At the end of March 2013 all these responsibilities were handed over to the local authority. This process had the potential to be disruptive for the running of the Deprivation of Liberty Safeguards system but over half of the local authorities had already undertaken the supervisory body role for hospitals under previous arrangements and said that their best interest assessors had the necessary knowledge and ability to carry out assessments in a range of hospitals. Others said that they were in the process of training their assessors, and signatories were being supported through regional networks (although some local authorities did not answer this question).

**However, some respondents expressed concerns that the MCA, including the Deprivation of Liberty Safeguards, is becoming less embedded in some hospitals since the abolition of primary care trusts and the transfer of their supervisory body responsibilities to local authorities. Local authorities are encouraged to recognise the importance of building and maintaining relationships with health partners in order to raise levels of awareness and understanding. We also recognise that through our inspections we have an important role to play in making sure that hospitals and care homes are engaged with the MCA, including the Deprivation of Liberty Safeguards.**

## Barriers to good practice

Eighty-five per cent of the local authorities that responded to our survey said that hospitals' and care homes' poor understanding of their role and function was a barrier to good practice. Seventy-five per cent indicated that a lack of understanding and awareness of the MCA in general was a barrier, and 73% indicated confusion over the criteria and definition in relation to deprivation of liberty. The most common themes were:

- **The complexity of application forms** which could lead to errors and delays in processing applications. We are aware of local authorities designing their own forms which are more user-friendly, for example, they combine the standard forms 1 and 4 to enable managing authorities to send an urgent authorisation together with a request for a standard authorisation without a lot of repetition of the same information.
- **Low levels of understanding and awareness in many hospitals and care homes** which is a longstanding and concerning issue. Almost all the local authorities surveyed described support (such as advice about potential referrals) that they provided to hospitals and care homes about the MCA and also their specific responsibilities under the Deprivation of Liberty Safeguards. A minority reported analysing applications to identify hospitals and care homes making few or no applications, and targeting awareness raising and training on those organisations or services.
- **Difficulties in meeting the seven day deadline for standard authorisations attached to urgent authorisations.** We have described above the most common reasons for this occurring.

Other barriers that were reported included: lack of availability of assessors; on-going confusion around defining a deprivation of liberty and the interface with the Mental Health Act; impact of disinvestment programmes on staffing numbers and on the increased use of restrictive practices; and the MCA not being embedded into routine care management.

It is important that providers and commissioners continue with activities to improve awareness and understanding of the MCA and the Deprivation of Liberty Safeguards, or urgently initiate activities to achieve this. We have included a number of examples given to us by local authorities of ways in which they raised awareness and improved understanding in hospitals and care homes.

We will continue to explore ways in which we can support further efforts to monitor and achieve this. We anticipate that this will involve surveying levels of awareness and understanding among staff in a sample of hospitals and care homes but we want to do this using a partnership approach with providers and in a way that also has some benefits for those organisations participating (such as providing useful feedback to staff and services about their use of the MCA).

In 2013/14 we will consult with a sample of provider organisations as well as with our external advisory group for the Deprivation of Liberty Safeguards on the best way to carry out this survey.

## **Mechanisms for understanding the experience of people subject to the Deprivation of Liberty Safeguards**

In our last report we said that providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Deprivation of Liberty Safeguards.

Although more than 80% of respondents to the local authority supervisory body survey said that they maintained contact with the person subject to the Safeguards or their representative, 17 said they did not do this. We plan to explore this area further, since in order to understand the experience of people subject to the Deprivation of Liberty Safeguards it is essential that all local authorities have ways of maintaining contact with them and their representatives.

## **Conclusions from the survey**

Like the IMCA survey reported on in Chapter 4, the local authority supervisory body survey paints a mixed picture of what the Deprivation of Liberty Safeguards system actually means to people, the extent to which it is being properly applied, and whether people are being treated with respect for their human rights. The survey tended to focus more on process issues rather than outcomes so it was easier to make inferences from the findings about how far the Deprivation of Liberty Safeguards were being used correctly and lawfully, than about implications in terms of people's direct experience of care and treatment.

Most local authority supervisory bodies are well engaged with the Deprivation of Liberty Safeguards. For people in hospitals and care homes subject to authorisation, notwithstanding low levels of awareness and understanding in

some hospitals and care homes, the Deprivation of Liberty Safeguards should be experienced as being protective, useful and consistently applied. However, there was evidence from the survey, taken with the information from the HSCIC and from the IMCA survey as well, that some local authorities understand and are carrying out their responsibilities much more effectively than others. The apparent lack of involvement of the person, their representative and IMCAs in some areas is particularly concerning and could cause confusion and possible distress for the individual involved, as well as being unlawful. Difficulty meeting statutory deadlines is also a source of concern.

**The MCA has been in effect since 2007, and the Deprivation of Liberty Safeguards since 2009. There is no excuse for services whose central function is the care and treatment of adults, including some of the most vulnerable people in society, not to have achieved a clear framework of MCA-compliant policy and practice, including an emphasis on reduction of restriction and restraint, and an informed use of the Deprivation of Liberty Safeguards.**

The survey focused on the Deprivation of Liberty Safeguards system and in future surveys of this type we will gather information about the wider context of the MCA, especially the assessment of capacity and best interests decision making, and how they are reflected in care plans that promote peoples' independence and liberty wherever possible. We are committed in our new strategy to working more effectively with our partners in health and social care, building relationships with those we regulate, and making better use of the information we have available.

# 04 Better understanding the experience of people who have been the subject of authorisation applications

## Key points

- We are very grateful to the IMCAs who helped us this year by completing our survey on the experiences of people personally affected by the Deprivation of Liberty Safeguards. We plan to build on this next year, by interviewing people identified by local authorities or IMCAs as agreeing to talk to us.
- The IMCA survey provided some important and useful insights into the experience of people who may be subject to the Deprivation of Liberty Safeguards and their representatives. It paints a mixed picture of people's experience, with some evidence of good practice but also evidence of people still not always being listened to or involved in important decisions about their lives or the lives of a relative or close friend.
- There appears to be variation in practice among IMCAs in how actively they encourage people subject to authorisation and their representatives to ask for reviews or to challenge the authorisation to the Court of Protection. We encourage IMCAs to share knowledge of how and when to do this, and IMCA organisations to support their staff to gain the knowledge and confidence to help people affected by the Deprivation of Liberty Safeguards to challenge the status quo.



A crucial part of monitoring the Deprivation of Liberty Safeguards is to understand what they mean to the patients and residents who are subject to them and to see if they improve people's experience of care or treatment.

Obtaining the views of people with severe dementia or profound learning disabilities can be very challenging. If people lack capacity to give their consent to the arrangements proposed for their care and treatment, and if these arrangements amount to a deprivation of liberty in a hospital or care home, it can be very difficult to obtain their views about what being deprived of their liberty means to them in practice.

Nevertheless, consultation with and involvement of the person at the heart of the process, their family or friends, and their representative once appointed, is a legal requirement of the assessment process.

In last year's report we explored an approach to understanding the experiences people have of the Deprivation of Liberty Safeguards in practice. We did this by conducting interviews focusing on the experiences of 10 people who either were or had been subject to the Safeguards. The interviews were with four members of staff and six family members or friends.

This year we have tried to gather this information mainly through a survey of Independent Mental Capacity Advocates (IMCAs). IMCAs have particular roles to perform for people subject to the Safeguards, and for those people appointed as the 'Relevant Person's Representative' (RPR). The RPR is usually a close relative or friend of the person subject to the Deprivation of Liberty Safeguards (the 'relevant person'), and cannot be someone employed to provide care or treatment to them. If there are no family or friends able or willing to carry out the role, the supervisory body must appoint a paid RPR, often an advocate but usually not an IMCA.

Involving IMCAs to get the views of people and their representatives has obvious limitations and in the future we intend to explore other ways of getting first hand views of the Deprivation of Liberty Safeguards system. However, IMCAs are not only able to engage and understand the views of people who may lack capacity in ways not necessarily available to health and social care practitioners, but they also have a good understanding of the MCA and the Safeguards system from a human rights basis. We are therefore likely to build on this approach in the future and ask IMCAs to provide further information about their specific roles within the Deprivation of Liberty Safeguards.

## Survey methodology

We contacted a sample of IMCA provider organisations, covering regional organisations and national organisations with local IMCA services. Where possible, we selected organisations that has achieved a nationally recognised quality mark for IMCA provision. We asked them to complete a web survey in July and August 2013. The findings are based on 24 responses and the case studies are taken from examples given by respondents. We are most grateful to those who replied. Not all respondents answered all questions, and in at least one case the IMCA had never carried out any specific work under the Deprivation of Liberty Safeguards.

## Findings

### Taking into account the views of the person and/or their representative as part of the assessment process

Twenty-one out of 22 respondents said that the perspective of the person and/or their representative was taken into account at least “some of the time” and 11 respondents felt it was “most or all of the time”. In this and other answers to the IMCA survey it must be remembered that IMCAs are not involved in the initial assessment process unless the person has no family or friends to be consulted. Therefore their opinions are likely to be a mixture of direct experience, hearing of the experiences of colleagues, and supposition.

Examples of good practice that were offered included making sure that all relevant views were heard in situations where there was a dispute over a person, staff working to minimise restrictions, and examples of MCA-aware and proactive hospitals and care homes.

While these are positive indicators it is concerning that nearly half of the respondents believed that the views of the person and their representative were only taken into account “some of the time”. Best interests decision-making, within the Deprivation of Liberty Safeguards and within the wider MCA, should always include some indicators of the person’s perspective and must include consultation with the representative if one has been appointed.

#### Taking into account the views of the person



L had dementia, was in hospital, in a wheelchair, and was awaiting discharge to new sheltered accommodation. He frequently asked to go home or to leave the ward to smoke. On occasion he had been allowed off the ward unsupervised and called himself a taxi to take him home. A Deprivation of Liberty Safeguards authorisation was granted while a suitable placement was found. L’s social worker helped him to have

time off the ward – she took him to the local high street so he could get some money and buy cigarettes. Hospital staff and his neighbour accompanied him to have a cigarette in the hospital grounds. This practice, focused on his holistic best interests within the MCA, enabled L to become more settled and happy in hospital while his sheltered accommodation was arranged.

### Changes in restrictions

There were very mixed views expressed by IMCAs about changes in restrictions. Slightly more respondents to the survey (five) felt that there had been a decrease in the number of restrictions they observed than those who believed there had been an increase (three), although the largest number (seven) thought that the number had stayed the same.

One IMCA commented that care homes are not always managing objections by a person when they express the desire to leave to “go home” (when the care home was in fact their home). The care homes simply prevented them from leaving, which caused the person more distress and agitation. Once the care home was guided through alternative ways of dealing with these situations, such as distraction techniques, the objections usually stopped.

## Reducing restraint and promoting liberty



N’s wife was appointed as his representative, and offered the support of an IMCA. The Deprivation of Liberty Safeguards enabled a gradual reduction in restraint to be achieved through regular reviews and the flexibilities of the care staff. N started to return home on regular visits, having been deprived of these visits for a considerable period of time. Without the authorisation, the IMCA did not feel the support would have been

in place to challenge the care plan. Reductions in medication and a massive improvement in social stimulation enabled N to overcome some stereotypical ‘type-casting’, for example he had previously been judged “aggressive”. He became better understood and his care more person-centred.

## Maintaining contact with the person and/or their representative

Twenty out of 24 respondents said that IMCAs maintained contact with the person and or their representative “some”, “most”, or “all of the time” for the duration of a standard authorisation, but only three did this all of the time. The most common reason for ending involvement was that the person, or their representative, had decided they did not need or want any further support from the IMCA (although it wasn’t always clear whether they were referring to the person or their representative, or whether people felt able to re-refer themselves later if they wished).

The obvious way for a supervisory body to create and enable a relationship between an IMCA and the relevant person and their representative is to commission an IMCA under MCA s39(d) whenever an authorisation is granted, to support the person and their unpaid representative (though regulations do prevent supervisory bodies from commissioning an IMCA under this part of the Act where the representative is paid, and we do not know from this survey how paid representatives, often advocates who are not IMCAs, are supported).



### Good practice example:

- One IMCA service described having a system in place whereby the IMCA re-contacted the representative half way through the authorisation period and a month before the end of the authorisation. This was to remind them that, if they needed support, they could ask for a re-referral to be made by the local authority.

## Objections to situations assessed to be deprivation of someone's liberty

The response by hospitals, care homes and local authorities to objections raised about restraint or deprivation of liberty gives an important indication of whether the person or their representative is being listened to and their concerns taken seriously.

Respondents to the IMCA survey were asked for examples of objections raised by the person or their representative, and the effect on the person. In the first of the examples below, the IMCA felt that the Deprivation of Liberty Safeguards improved the lives and provided protection for the rights of this couple. In the second example, the IMCA remained concerned that the person still suffered greatly from being detained.

### Objecting to restrictions



P was acting as representative to his wife. He objected to them only being allowed supervised contact, without sufficient privacy, by the care home where she lived. The local authority reviewed the authorisation. The best interests assessor made it clear that if the care home

wished to restrict or supervise contact, they should apply to the Court of Protection. The care home agreed to remove the restriction but agreed with P and his wife that, if they went out of the care home, staff could observe from a discreet distance.

### Objecting to restrictions



Q was a man in hospital with severe dementia. He was waiting to be discharged to a nursing home. He was constantly wandering and trying to leave the ward, and he frequently talked about being a prisoner. Having the Deprivation of Liberty Safeguards authorisation in place appeared to make no difference to how Q felt. It was a condition of the authorisation that he was

regularly taken out for walks, but since he didn't remember these walks he still said he was never taken out of the ward. The condition that staff must take him out did not relieve the impact on Q of being deprived of his liberty.

## Seeking reviews

Reviews, as discussed in chapter 3, are an important means of finding out, or exploring, at a local level whether the deprivation of liberty is necessary and to consider whether the care or treatment can be provided in a less restrictive way – a key principle of the MCA.

There is no automatic review process of the Deprivation of Liberty Safeguards similar to the Tribunal system available to people those who are detained under

the Mental Health Act. A review under the Safeguards is not a substitute for the requirement under the Human Rights Act 1998 Article 5(4) that a detained person must have speedy access to a court, which has the power to discharge the detention, to challenge it – the supervisory body which carries out reviews does of course have the power to lift an authorisation but it is not independent or judicial. A review request is, rather, a valuable chance for the supervisory body to revisit an authorisation or any aspect of it, to investigate whether it is still justified, and quickly make such changes as are required.

Review requests from the person or their representative should therefore be acted on quickly, both so that identified changes can be made as soon as possible, and also so that they do not impede a person's right to challenge the authorisation to the Court of Protection, if the person making the request remains in dispute with the supervisory body. The Code of Practice to the Deprivation of Liberty Safeguards explains that, if a review is requested by the relevant person, their representative or the managing authority, then the supervisory body must carry out a review. In addition, a supervisory body may at its discretion review any authorisation, perhaps as the result of a request or information from a third party.

Generally, the authorisation must be reviewed if the person is thought to no longer meet any of the 'qualifying requirements', for example, they may have regained capacity or no longer have a mental disorder. A managing authority must monitor authorisations on an ongoing basis to see if the person's circumstances change, which may mean they no longer need to be deprived of their liberty. If that is the case, they must ask the supervisory body to conduct a review in order to lift the authorisation.

An IMCA appointed under MCA s39(d) is under a duty to assist the relevant person, or their representative, to challenge an authorisation to the court of protection. In addition, if they think the authorisation should be reviewed, they should ask the supervisory body to do this. Asked whether these IMCAs had asked for reviews of authorisations, some appeared more inclined to do this more than others, with 13 of the 24 respondents not instigating any at all.

The most common area for reviews appeared to centre on challenging the best interests assessment, or asking for changes to the conditions of the authorisation.

11 respondents said they had initiated a total of 30 reviews. Fourteen of these reviews had been instigated by three respondents. The majority of reviews either challenged the best interests assessment, or asked for changes to the conditions of the authorisation.

Some IMCAs described the review process as time consuming and cumbersome, though there is no reason why it should be so. We would encourage IMCA services to monitor the number of challenges to court and reviews they request and their outcomes. We also encourage them to discuss any concerns with the local authorities they work with.

## Seeking a review



R was in a care home, subject to a Deprivation of Liberty Safeguards authorisation. Her friend did not want to be formally involved with the Safeguards system but then became concerned about the authorisation, saying the care home

and its staff were making R depressed. Her friend spoke to an IMCA who asked for a review. The result of this was to end the authorisation on the grounds that it no longer appeared to be in R's best interests.

We plan to look at ways local authorities and IMCAs encourage and support people subject to authorisation, and their representatives, to ask for reviews if they feel that there have been changes to their situation since authorisation. IMCAs who have 'learned the ropes' of the review process might be encouraged to share their knowledge and confidence with colleagues.

## Court of Protection appeals

Five out of the 24 IMCA respondents had appealed against a detention in the Court of Protection on behalf of the person or their representative in the previous year. It is encouraging that, in these cases at least, the IMCA role is fulfilling a major intention of supporting challenge to the Court. Although one respondent with experience of the Court felt that their involvement was an improved support to the person to attend their own hearing, others made references to the complicated nature of the process and how it could be intimidating for both the person and their representative.

## Conclusions

The IMCA survey provided some important and useful insights into the experience of people who may be subject to the Deprivation of Liberty Safeguards and their representatives. It paints a mixed picture of people's experience, with some evidence of good practice but also evidence of people still not always being listened to or involved in important decisions about their lives or the lives of a relative or close friend.

We recognise that the survey in many ways tells us about the IMCAs' own perspectives on the Deprivation of Liberty Safeguards, but this is useful in its own right as IMCAs have a uniquely important role in the Safeguards systems (as they do in the wider MCA).

Putting people who use services at the centre of our work is a fundamental principle for CQC, and finding out as much as we can about the experience of people who use services and their carers is a key commitment of our new three-year strategy. **Over the next year we will extend this work in collaboration with partner organisations.**

Although there are challenges to understanding people's experience of the Deprivation of Liberty Safeguards, we have noted from the local authority survey

reported on in the previous chapter that a number of applications to the Court of Protection were made either by the person subject to the Safeguards or their representative (who will often be a family member) sometimes with the support of an IMCA.

The focus of the survey was on the Deprivation of Liberty Safeguards, rather than the wider use of the MCA. But we believe that the Deprivation of Liberty Safeguards can only be applied correctly when there is a proper understanding of the MCA. Indeed, correct use of the MCA may mitigate the need for the Deprivation of Liberty Safeguards in some situations, by identifying ways to minimise restraint and promote people's liberty. People should for example be empowered to maximise their capacity to make their own decisions; capacity assessments must contain enough information, presented suitably, to ensure the person is given real choices; best interests decision-making must place the person, their views and life-story, at the heart of the process, illuminated by consultation with family and friends; any restriction of the person's freedom and right to a private and family life must be recognised, and every attempt made to discern and use less restrictive options. **In gathering the views of people directly affected by the Deprivation of Liberty Safeguards, we will, together with providers, IMCAs and local authorities, also try and find out more about their experience of the MCA more generally.**

An IMCA who completed our survey commented on the use of the Deprivation of Liberty Safeguards to encourage people to gain (or regain) mental capacity to make their own decisions, with the outcome that they are supported to implement their own decisions. This IMCA identified a risk, particularly for people who fund their own care and have little or no contact with social services, or who have no family or friends to visit, that without this process the presumption that they 'lack capacity' might continue unchallenged.

We comment elsewhere on how managing authorities cannot properly understand when to use the Deprivation of Liberty Safeguards unless they understand where they sit within the MCA. This is an example of the Safeguards supporting development of this wider understanding.

# Conclusions

There is evidence of the Deprivation of Liberty Safeguards system working well in places both in terms of compliance with the law and people's experience. There also seems to be a positive trend in awareness and understanding of the Safeguards in some hospitals and care homes and in many local authorities.

However, the evidence also indicates that in many care homes and hospitals, little appears to have changed from the situation we described in last year's report. When our monitoring information is looked at with data from the Information Centre it is difficult to avoid the conclusion that some people in care homes and hospitals may continue to be subject to restraint and possible deprivation of liberty without the full protection of the law.

## Efforts must be increased to achieve the expectations from last year's report:

- Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- Care providers must implement policies that minimise the use of restraint.
- Providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Deprivation of Liberty Safeguards.

## Programmes and activities undertaken by providers and local authorities to address the concerns must continue.

We recognise the important role we have in promoting good practice under the MCA and we will continue to implement our commitments, in line with our new three year strategy, over the coming year.

## We expect:

There must be the best possible communication, consultation and sharing of information, by supervisory bodies and managing authorities, with the person directly affected by the Safeguards, their representatives and other close relatives and friends.

Care homes, hospitals and local authorities must work together locally to raise awareness and improve understanding of the Safeguards and the MCA more widely

Hospitals and care homes must significantly improve their notification rates to us. Our notification forms can be found on our [website](#).

### We recommend:

- That NHS England include expectations on the effective use of the Deprivation of Liberty Safeguards into the standard contract for providers.

### We encourage:

- Local authorities who do not robustly monitor the Deprivation of Liberty Safeguards to analyse various aspects of their systems, especially about meeting statutory deadlines and communication with people directly affected by the Safeguards.
- IMCA services to monitor their levels of activity around requesting reviews and supporting challenges to the Court of Protection.

### We will:

- **Increase our efforts to capture the experience of people who are, or have been, subject to authorisation, and of their families and friends.** We will do this in two main ways. Firstly we plan to work further with supervisory bodies and IMCAs to identify people who are or have been subject to the Deprivation of Liberty Safeguards, and their relatives or friends, who would be happy to be interviewed about their experiences, and discover as much as we can about their experiences.

Secondly, building on our work with supervisory bodies and IMCAs, we will particularly look at the situations of people who have been subject to a succession of authorisations over a year or more, who will be identified for us by supervisory bodies and/or the care homes or hospitals where they have been living. We will ask the following questions of the hospitals or care homes, and of the supervisory bodies who are granting these authorisations: Are all possible efforts made to reduce restraint? Are the person's best interests being identified and promoted holistically? Are people in the right settings? Are their rights to challenge the authorisation to the Court of Protection being facilitated and promoted?

- **Make sure the MCA is embedded into the way we operate.** We will continue to improve the knowledge and confidence of our inspectors, and encourage them to support all the services we regulate towards confident, human rights-based MCA compliant practice. As part of this, we will update the materials available both to inspectors and users of our website. We will also weave the MCA into the key lines of enquiry which are being developed as part of our new approach to regulation and inspection for all sectors and, wherever relevant, into the indicators of 'what good looks like'.

- **Continue to build on our collaborative relationships, with local authorities to promote improvements in Mental Capacity Act compliance across the health and social care system.** Building on the success of this year's collaboration with local authorities, CQC's Chief Executive will write to all directors of adult social care encouraging them to prioritise continued collaboration with CQC with the mutual objective of understanding the impact of the Deprivation of Liberty Safeguards system on people's experiences of care. We plan to repeat the survey approach and follow up interviews in next year's programme of DoLS monitoring work
- **Promote understanding of the Deprivation of Liberty Safeguards in care homes and hospitals.** In consultation with provider organisations and our external advisory group we will develop a survey of levels of awareness and understanding among hospital and care home staff of the Deprivation of Liberty Safeguards system and the MCA more widely.

We recognise that 2013/14 is a year when the Deprivation of Liberty Safeguards, together with the MCA more generally, have come under close scrutiny – particularly by the House of Lords and the courts. We will monitor these developments closely and incorporate emerging information into our work.

We believe that the Deprivation of Liberty Safeguards, when used correctly and within the wider context of the MCA, provide very important and effective protection for people who lack capacity to make decisions about their care and treatment. We recognise that there remains on going work to improve awareness and understanding of the Deprivation of Liberty Safeguards system and we will therefore consider carefully how we can support initiatives aimed at improving awareness and understanding of these important legal processes in order to protect and enhance the experience of people using the health and social care services that we monitor and regulate.

The final report of the Public Guardian Board, the body set up under the MCA to oversee the Public Guardian, was published in 2012. The report significantly called for "an independent Champion for the Mental Capacity Act, to ensure the Act's potential is realised". In the introductory letter, the Lord Chancellor also says:

“*The MCA enshrines the rights of every citizen to exercise choice and to receive assistance to do so when their ability is limited: quite simply “No decision about me without me.” To achieve this, we believe many different players from across government, health, social care and the third sectors need to work together.*”<sup>7</sup>

We are committed to working in active collaboration with all the different parts of the system, nationally, regionally and locally, to play our part in realising the full potential of the Mental Capacity Act.

<sup>7</sup> Ministry of Justice: Public Guardian Board Annual Report, London, TSO 2012: *introductory letter to the Lord Chancellor*

# Appendix A:

## Developments in case law

### Meaning of deprivation of liberty

In last year's report we highlighted that the Supreme Court had given its leave for the two significant cases of *P and Q -v- Surrey County Council* [2011] EWCA Civ 190, and *Cheshire West and Cheshire Council -v- P and M* [2011] EWCA Civ 1257 to be appealed. Although this appeal did go ahead on 21st October, at the time of writing, the decision and judgments have not been handed down. It was acknowledged last year by Baker J in the case of *CC -v- KK and STCC* [2012] EWHC 2136 (COP) that while those appeals are pending, there can be no legal certainty about what might constitute a deprivation of liberty. In particular, the question of whether the objective element of the person's confinement can be assessed by reference to their individual circumstances or limitations remains to be resolved. There have been relatively few cases touching on the meaning of deprivation of liberty during this year, and that is undoubtedly as a result of the wait for a Supreme Court decision on this important issue.

The most significant case on this matter has been of **A PCT v LDV, CC and B Healthcare Group** [2013] EWHC 272 (Fam) which came before Baker J in the Court of Protection in February 2013. The case involved L, a young woman formerly resident at Winterbourne View, who had a mild learning disability and unstable personality disorder. She was to be moved into a residential unit near to her home, but pending the availability of a suitable placement, went to a medium secure hospital (WH). In May 2012, L's detention under the MHA was ended by a tribunal, but on moving to WH the Trust recommended that she be re-detained under the MHA. In assessing L for this, the AHMP found that her circumstances had not changed, making further detention under the MHA impossible. The AHMP also found L's circumstances in WH to amount to a deprivation of her liberty, but that as she was also within the scope of the MHA, she was ineligible to be so detained. The PCT with responsibility for WH therefore brought the matter before Court of Protection for guidance.

Baker J considered first of all, whether L was being deprived of her liberty, and described briefly the current legal position, acknowledging how uncertain it was pending the decision of the Supreme Court. He referred to his own judgment in the case of *CC v KK* (mentioned in last year's report) as being the most recent statement of the law on this matter, but also commented on the recent development of European case law, referring to the cases of *Stanev v Bulgaria* (2012) 55EHRR 22, *DD v Lithuania* (application 13469/06) and *Kedzior v Poland* (application 45026/07). Baker J said that an analysis of the effect of these cases on English law would be undertaken by the Supreme Court in the course of the appeal, and that to anticipate the results would not be helpful.

In L's case, Baker J considered the following restrictions on her movements to be significant:

- WH is locked to patients and visitors.
- L must seek permission to leave WH.
- L receives 1 – 1 supervisions when in the community.
- Staff would prevent L from leaving WH, should she be assessed as being at risk.
- Staff would discourage L from leaving, using de-escalation techniques, in any event.
- Police would be alerted if L did leave WH.
- L is restricted even within WH.
- L is observed at varying levels according to risk.
- Restraint is used if L is assessed to be a risk to herself or others.
- Staff would remove L from an area to de-escalate the situation.
- Staff may search L's personal property, where they perceive a risk.
- Staff may conduct personal searches of L, where they perceive a risk.
- Staff may administer sedatives when necessary, including intravenously.
- L may not have contact with her mother at WH.

He rejected the proposal that similar restrictions would have to be applied to L wherever she were to live, and found it "manifestly clear that L's circumstances amount to a deprivation of liberty." In finding this to be the case, he agreed with all of the significant professionals who had made assessments – the Approved Mental Health Professional, the Best Interests Assessor and her doctor had all considered L was being deprived of her liberty.

## Best interests

In **Re M [2013] EWHC 3456 (COP)** the Court of Protection considered how the best interests test in s4 of the Mental Capacity Act 2005 applied to M, a woman resident in a care home subject to a standard Deprivation of Liberty Safeguards authorisation. An application was made under s21A of the Act, under which the Court of Protection can determine a variety of issues including, as was the case here, whether the qualifying requirements for the authorisation are met. It was argued on M's behalf that the authorisation was no longer in her best interests.

M's circumstances were unusual, in that she did not lack capacity for most decisions, but did so in relation to management of her health and, resulting from that, determining where she should live. M suffered diabetes, which she believed she could manage herself. However, in 2011 she suffered five separate attacks of a potentially life threatening complication, diabetes ketoacidosis, and in 2012, was admitted to hospital on two further occasions with high blood sugar. These in turn led to her becoming bedbound, incontinent and confused. Admission to a care home under the auspices of a standard Deprivation of Liberty Safeguards authorisation followed. M's health improved there, but within a few months she became dissatisfied with her circumstances and wished to return home.

The application was opposed by the care commissioning group that had arranged M's placement, and evidence was given by both medical and care staff. All believed it to be in M's best interests that she remains at the care home, and so subject to the authorisation, as she was guaranteed to receive good physical and medical care. M, however, believed her quality of life otherwise to be so poor that she had no interest in remaining there. She wanted to return to the independence and familiarity of her home, and to be with her partner – in her own words, she wished “to be out of here quick or be dead.”

The judge, Jackson J, had to weigh, “the almost complete certainty of physical safety” with “the cost of the happiness”, and in the end he chose the possibility of M's happiness, concluding that the case for a continuation of the deprivation of her liberty was not established as meeting her best interests. While recognising the risks to M's health of returning home, he also took account of the risks to her health both physical and mental of remaining in the home against her will. In summarising the reasons for his decision, he said, “In the end, if M remains confined in a home she is entitled to ask “What for?” The only possible answer that could be provided at the moment is “To keep you alive as long as possible.” In my view that is not a sufficient answer.”

The judge went on to conclude that the state's obligation to protect life under the European Convention for Human Rights is not absolute, and allowed the possibility of decisions about the deprivation of liberty to be made with discretion according to an individual's best interests. Although the particular circumstances of M are unusual, the dilemma placed before the court is not. This case may therefore have wider application in months to come.

## Eligibility for Deprivation of Liberty Safeguards

The interface between the Mental Capacity Act 2005 and the Mental Health Act, in the field of deprivation of liberty, remains a complex matter. Two cases taking place this year have confirmed this to be the case, without providing any simplification.

The first is the case of **A NHS Trust v Dr A [2013] EWHC 2442 (COP)**. Dr A, an Iranian doctor requesting asylum in the UK, was on hunger strike in the applicant's hospital, where medical staff were proposing to force feed him. Dr A had previously been treated for mental disorder, and it was suggested that he might be suffering delusional disorder. The Trust applied to the Court of Protection for a declaration that it would be lawful to administer artificial hydration and nutrition, in circumstances which would involve depriving him of his liberty.

Dr A's eligibility for the Deprivation of Liberty Safeguards was the main issue in this case. If he was suffering from an impairment or disturbance of the brain such that he was within the scope of the MHA, this would, under section 16A MCA, make him ineligible for the Deprivation of Liberty Safeguards. Baker J considered in detail the implications of authorising the treatment under both Acts, and finally concluded that as he was not eligible for either, the Court of Protection could authorise the treatment under its inherent jurisdiction. In doing so he stated that in future, and until the precise effect of s16 A could be clarified by the Court of Protection or another court, if a hospital wished to give treatment to a patient who is potentially ineligible for the Deprivation of Liberty

Safeguards under s16A, which was not within the scope of “treatment” under the MHA, but nevertheless involved depriving the patient of their liberty, they would need similarly, to obtain an order under the court’s inherent jurisdiction.

This case establishes that the inherent jurisdiction continues to provide a mechanism for authorising deprivation of liberty and treatment, despite both the MHA and MCA providing their own regimes. Where the application of these two regimes causes conflict, there is a third alternative.

The second is the case of **South London and Maudsley NHS Foundation Trust v Secretary of State for Health [2013] UKUT 0365**. This involved an elderly lady, AM, who had been detained in hospital under the MHA. She did not wish to be detained under the MHA and so applied to the first tier tribunal for her detention to be ended. Her application was refused, and an appeal to the Upper Tribunal resulted. Clinicians wished her to remain in hospital, and to continue to receive treatment. In concluding that the first tier tribunal had erred in law by not fully considering whether MA would comply with the proposed treatment, Charles J considered at length the approach that should be taken by the First Tier Tribunal and “other decision makers under the MHA” when there is a possibility of the same treatment being given under the MCA. He found that the MHA “necessity test” required consideration of how the recommended treatment could be administered, and that this should involve determining the least restrictive way, whether under the MHA or the MCA. He offered a summary of when each of those might be applicable. He said that “The theoretical and practical availability of the MCA regime and its Deprivation of Liberty Safeguards is one of the factors that needs to be considered by the MHA decision maker”, implying that detention under the Deprivation of Liberty Safeguards would be less intrusive than detention under the MHA. No conclusions were reached regarding MA’s own eligibility or otherwise for the Deprivation of Liberty Safeguards. The case suggests that people making decisions about how the treatment they have recommended should be delivered should choose the least intrusive and therefore potentially more acceptable legal framework.

## Involving families in decisions

It is not only courts that have considered the DOLs regime this year – in November 2013, the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman services published their joint decision following a complaint made to them about the treatment of an elderly couple, both of whom suffered dementia. The couple’s son, himself a doctor, had been involved in making arrangements for his parents’ care since 2009, but following his father’s admission to respite care and his mother’s admission to hospital, the local authority and local NHS Trust proceeded to make hasty plans for the couple’s care without further reference to him. In particular, an application for a DOLs authorisation was made, and approved, in respect of the elderly man without involving his son. He had made care arrangements that would have assisted his parents to live together at home for longer, but these were overridden. The Ombudsman service concluded this was wrong, and had led to poor outcomes for all concerned. The local authorities involved – Kirklees Metropolitan Borough Council and the South West Yorkshire Partnership NHS Foundation Trust – agreed with the findings and to pay compensation to the couple affected.

Although decisions of the Ombudsman do not affect the law, they can affect practice within health and social services. Following consideration of this case, the local authorities concerned apologised to the family, and have publicly recognised the inappropriateness of their actions.

Julie Mellor, Health Service Ombudsman, said:

**“** *Involving their son could have led to better outcomes for the couple. Families and carers can have the key to understanding the needs of their loved ones. That’s why public services must, in law, involve families and carers in making life changing decisions for vulnerable people.”*

# Appendix B:

## Resources on the Mental Capacity Act, including the Deprivation of Liberty Safeguards

Document(s)	Brief/provider	Website link
Mental Capacity Act 2005: code of practice	Government: statutory guidance for professionals	<a href="http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf">http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf</a>
Mental Capacity Act 2005: Deprivation of Liberty Safeguards code of practice	Government: statutory guidance to supplement the main Mental capacity Act 2005 Code of Practice	<a href="http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf">http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf</a>
Information on LPAs and Deputyships	Office of the Public Guardian: forms and guidance	<a href="http://www.justice.gov.uk/about/opg/">http://www.justice.gov.uk/about/opg/</a>
Consent to treatment	NHS on-line resource: assessing capacity, consenting to treatment	<a href="http://www.nhs.uk/conditions/consent-to-treatment/Pages/Introduction.aspx">http://www.nhs.uk/conditions/consent-to-treatment/Pages/Introduction.aspx</a>
Reference guide to consent for evaluation or treatment, second edition 2009	Guide to the legal framework that all health professionals need to take into account when getting consent for treatment	<a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643</a>
Application for a search of the Public Guardian registers	Office of the Public Guardian: Form to search to see if someone has a LPA or deputy acting on their behalf	<a href="https://www.gov.uk/find-someones-attorney-or-deputy">https://www.gov.uk/find-someones-attorney-or-deputy</a>
Mental capacity toolkit online	British Medical Association: online resource with downloadable sections about assessing capacity, basic principles of MCA, LPAs	<a href="http://bma.org.uk/practical-support-at-work/ethics/mental-capacity-tool-kit">http://bma.org.uk/practical-support-at-work/ethics/mental-capacity-tool-kit</a>
Range of resources on MCA including Deprivation of Liberty Safeguards and audit tools	Social Care Institute of Excellence	<a href="http://www.scie.org.uk/publications/mca/index.asc">http://www.scie.org.uk/publications/mca/index.asc</a>
Range of MCA resources	Alzheimer's Society	<a href="http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=354">http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=354</a>

MCA literature review and other resources	Mental Health Foundation	<a href="http://www.mentalhealth.org.uk/publications/mca-lit-review/">http://www.mentalhealth.org.uk/publications/mca-lit-review/</a>
Help with managing money if you or someone you care for lacks mental capacity	Money Advice Service: guide for people with LD or MH issues.	<a href="https://www.moneyadviceservice.org.uk/en/articles/free-printed-guides?utm_source=NHSChoExt&amp;utm_medium=Website&amp;utm_campaign=NP-JF">https://www.moneyadviceservice.org.uk/en/articles/free-printed-guides?utm_source=NHSChoExt&amp;utm_medium=Website&amp;utm_campaign=NP-JF</a>
Mental Capacity Act resource pack	Mencap: guide for families of people with learning disabilities	<a href="http://www.mencap.org.uk/sites/default/files/documents/mental%20capacity%20act%20resource%20pack.pdf">http://www.mencap.org.uk/sites/default/files/documents/mental%20capacity%20act%20resource%20pack.pdf</a>
Deprivation of Liberty Safeguards	Rethink: fact-sheet on Deprivation of Liberty Safeguards with links to Mental Health Act and wider MCA	<a href="http://www.rethink.org/living-with-mental-illness/mental-health-laws/deprivation-of-liberty-safeguards">http://www.rethink.org/living-with-mental-illness/mental-health-laws/deprivation-of-liberty-safeguards</a>

# Appendix C:

## External Advisory Group

An Advisory Group of people with expertise in the Mental Capacity Act and the Safeguards advised us on the production of this report. The group helped to test ideas, share information on the operation of the Safeguards in practice, and develop more collaborative approaches to our monitoring role.

We are grateful to the group for the time, support, advice and expertise they have given, and in particular Toby Williamson and the Mental Health Foundation for their work on the report.

The members of the group were:

Name	Organisations
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Toby Williamson	Mental Health Foundation
Beverley Dawkins	Mencap
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Lucy Butler	Association of Directors of Adult Social Services
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