Summary

Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2010/11

The Care Quality Commission's second report on the implementation and use of the Safeguards

Introduction

The Deprivation of Liberty Safeguards ("the Safeguards") came into effect in 2009. They are part of a legal framework set out in the Mental Capacity Act 2005, and their aim is to ensure that people's human rights are protected in certain care settings when they are deprived of their liberty.

They do this by creating a system for people who are unable to make decisions for themselves about their care. The Safeguards can be used for adults aged 18 or over, who are in hospitals or care homes. People who may need the protections offered by the Safeguards typically include those with severe learning disabilities, people suffering from dementia, and people with brain injuries.

Hospitals and care homes as the 'managing authority' must apply to their local PCT or council (the 'supervisory body') for authorisation of a deprivation of liberty. The supervisory body will then make assessments to determine whether a deprivation is legal, including a test of whether it is in the person's best interests.

What constitutes a deprivation of liberty and when to apply the Safeguards is a complex area. There are also challenges for both managing authorities and supervisory bodies in keeping abreast of the latest judgements.

The Care Quality Commission (CQC) has a duty to monitor the operation of the Safeguards in England and to provide advice and information on their use. This is our second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards and covers 2010/11, the second year of their use.

Key findings

There is a clear need for, and value of, a system to safeguard the rights of people who lack capacity and are deprived of their liberty.

By integrating our monitoring of the safeguards into our mainstream regulatory work we have been able to see that many providers have developed positive practice, notably in involving people and their carers in the decision-making process.

But while the number of applications for authorisations under the safeguards rose there continue to be areas that need to be addressed. There is some confusion about what constitutes a deprivation of liberty and this can cause inconsistent practice.

A 'rump' of providers have still not trained their staff in the Safeguards. We have identified that there is a need to increase understanding to ensure people's rights are properly protected. Training and guidance, including updates, are likely to be key to developing consistent practice.

There is a particular gap in information on the role of supervisory bodies which has hindered our ability to monitor the Safeguards.

There continue to be concerns about the complexity of the Safeguards, in terms of content, processes and responsiveness. We will continue to discuss this with the Department of Health as and when our overview of the system enables us to identify areas for exploration.

Further detail

Applications and authorisations

Although the number of applications rose significantly in 2010/11, this was still much lower than the number anticipated by the Department of Health in their planning assumptions for England and Wales, which predicted 18,600 applications.

Between April 2010 and March 2011 8,982 applications for assessment were made by managing authorities of which 4,951 (55%) resulted in an authorisation for a deprivation of liberty being granted. This compares with the total for the previous year (2009/10) of 7,157 for which 3,297 (46%) applications were authorised. Once again this is significantly higher than the 25% expected by planners.

Supervisory bodies

Local authorities continue to receive a much higher number of applications than PCTs; 6,708 for local authorities compared to 2,274 received by PCTs. This is a ratio of 3:1, and is consistent with figures in 2009/10. In 2009/10, PCTs had a higher rate (49%) of applications granted compared to local authorities (45%). In 2010/11, the rate of approval in local authorities rose to 57% compared to an approval rate of 50% in PCTs.

Regional variation

The East Midlands had the highest percentage of applications across the country (18%) and the North East the lowest (6%). When taking population figures into account, the East Midlands also had the highest rate of applications per capita with 46 per 100,000 population, more than double the average rate of 22 per 100,000 population.

There is also variation within regions. In the East Midlands the rate of applications received by PCTs ranged from 1 to 31 per 100,000 people, and in local authorities from 11 to 65 per 100,000. In the North East the rate of applications received by PCTs ranged from 1 to 10 per 100,000, and in local authorities from 4 to 92 per 100,000 people.

Reasons for rejection

There were a number of reasons why authorisation was not granted. In the vast majority of cases (81%) this was because the 'best interests requirement' was not satisfied (including whether what was being proposed was actually a deprivation of liberty). This was followed by the mental capacity requirement not being met (10%), the eligibility

requirement not being met (6%) and the mental disorder requirement not being met (2%).

Differences in notifications

The review has shown there was a large shortfall in the number of notifications received by CQC compared with NHS and Social Care Information Centre (IC) figures. We received notification of 2,297 applications over a nine month period from October 2010 to June 2011 compared to the 7,165 applications to supervisory bodies as reported to the NHS IC over the same period.

Training and staff awareness

The report shows that staff training and awareness relating to the Safeguards varies a great deal. Around a third of the care homes that were asked about training on the Safeguards had not provided it for their staff. The level and grade of staff receiving training also varied. There was also some evidence that where training had taken place staff were not confident in their understanding.

In all the NHS hospitals reviewed there was evidence that at least some of staff had received training, however this ranged from 20% - 100%. There was also evidence where training had been given there was a rise in the number of Safeguards reporting.

Good and poor practice

A number of care homes showed good practice including the involvement of relevant professionals and advocates. However poor practice included evidence of restrictions being placed on people without proper assessments being made.

NHS hospitals showed evidence of using multi-disciplinary assessments involving patients, their relatives, carers and advocates used in making decisions. Poor practice included documentation not being completed properly and a general lack of confidence among staff and ward level leaders in using the Safeguards.

Conclusions and next steps

Our inspection findings show that there continue to be cases where people who lack capacity are deprived of their liberty without regard to their human rights. There is a clear continuing need for a system of checks and safeguards around deprivation of liberty. The themes that we identified from inspections will serve as issues that our inspectors will particularly take into account when planning visits over the next year.

Whether the current system is the best way to organise and administer protections for people who lack capacity and may be deprived of liberty, continues to be a subject of debate.

We are clear that our ability to monitor the Safeguards is improving year on year, but after two years of their operation there remain important gaps in information. Those gaps limit our ability to comment on the Safeguards' effectiveness overall. It is not

within our power alone to address this, but nonetheless we intend to take the initiative – in particular by broadening our approach to monitoring so as to involve other stakeholders more.

In order to provide an informed perspective we must further develop our understanding. We are committed to working with stakeholders to develop information flows and pool knowledge. By developing this across the system we can better address the issues raised.

We will continue to discuss with the Department of Health as and when we are able to identify any options from our overview of the system, for streamlining processes or maximising benefit to the individuals at the heart of the Safeguards.

The next stages of developing our approach to monitoring the Safeguards will have three strands:

- Further embedding the Safeguards as a routine and major part of our inspectors' practice
- Improving our information on managing authorities' applications and authorisations for the Safeguards
- Developing our ability to monitor the overall Safeguards "system", as well as managing authorities.