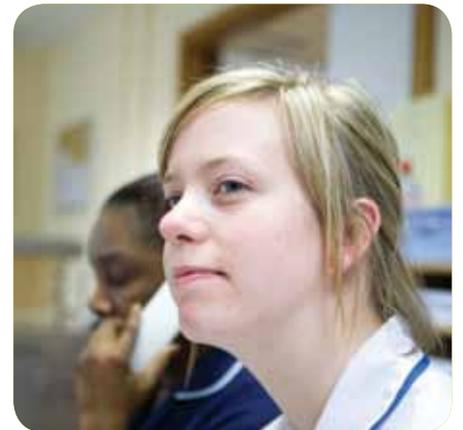


Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12



About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

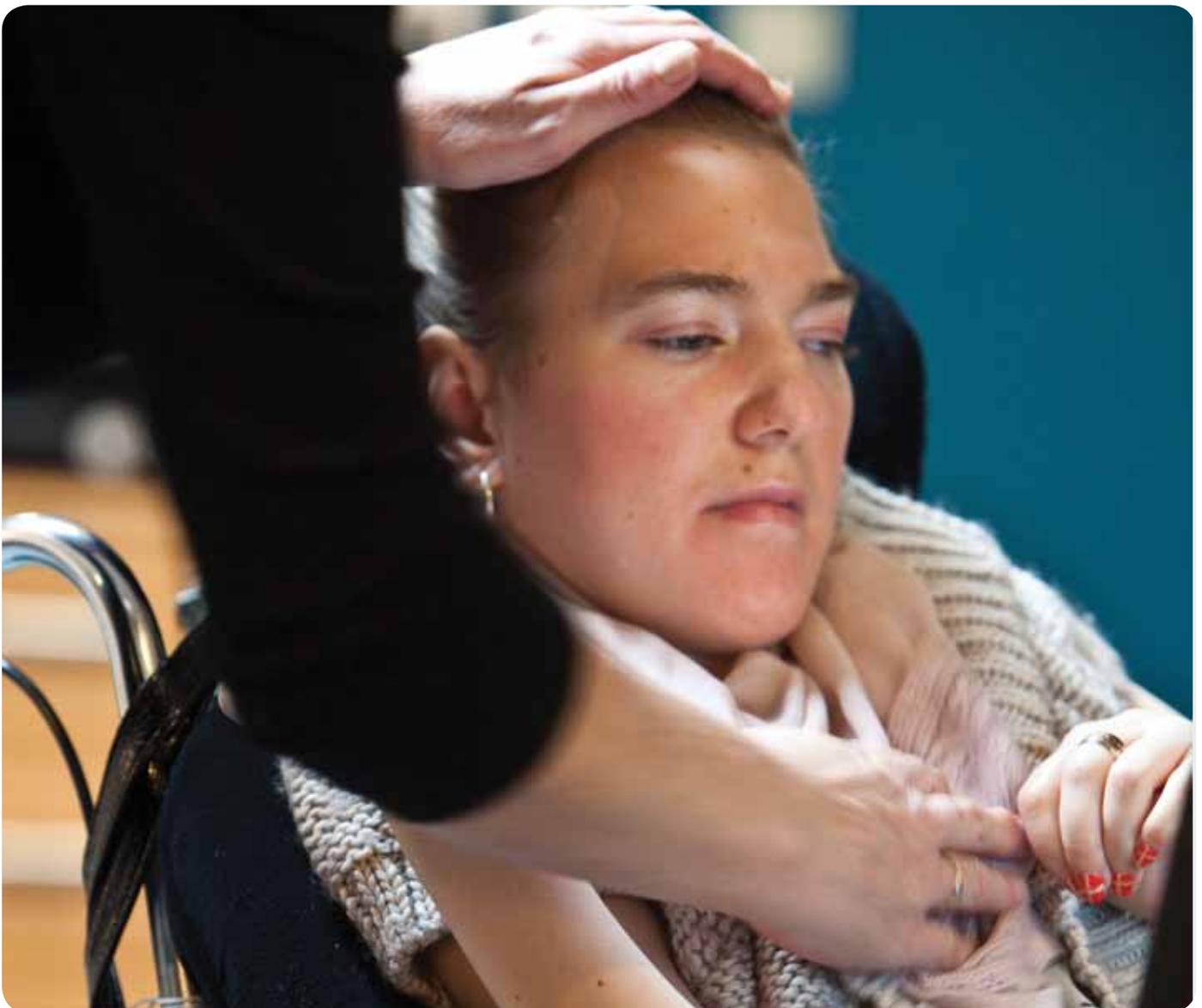
- **Identifying risks** to the quality and safety of people's care.
- **Acting swiftly** to help eliminate poor-quality care.
- Making sure **care is centred on people's needs** and protects their rights.

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Summary

This is the Care Quality Commission's (CQC's) third annual report on the Deprivation of Liberty Safeguards ("the Safeguards").



Purpose of the Safeguards

The Safeguards came into effect in 2009. They are part of a legal framework set out in the Mental Capacity Act 2005 (MCA). The MCA is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. It provides guidance to people who need to make decisions on behalf of someone else. It sets out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action.

The Mental Capacity Act is primarily concerned with people who have mental disabilities. The Safeguards are particularly relevant for those with severe learning disabilities, dementia, or people who have brain injuries. The Mental Health Act focuses on people who have mental illnesses. In practice, the same person may be covered by both Acts, depending on individual circumstances.

The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment. This problem was brought to light in the late 1990s by the case of Mr L and became known as 'the Bournemouth Gap'.¹

The reason the Safeguards were introduced The case of Mr L



Mr L was profoundly mentally disabled and unable to consent to medical treatment. He was admitted to hospital by a psychiatrist without the use of the Mental Health Act, as he was thought to be fully in agreement with this course of action.

His carers challenged this admission because of the restrictions on his liberty that were applied to him once in hospital and because Mr L did not have the capacity to disagree with the restrictions. The reality was that he was not free to leave.

The case went to the European Court of Human Rights, which agreed that Mr L had been deprived of his liberty within the meaning of Article 5 of the European Convention on Human Rights.²

The 'gap' that was identified was in the lack of safeguards for the admission and detention of people who appeared to agree but in fact lacked the capacity to consent or disagree.

There were no stated grounds for such action, no statement of purpose, no limits of time or treatment and no requirement for continuing clinical assessment. It was this gap that the Deprivation of Liberty Safeguards were designed to address.

¹ HL v United Kingdom (2005) 40 EHRR 761

² Article 5(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:... (e) the lawful detention... of persons of unsound mind.

There have been high profile failures in health and social care, which include deprivation of liberty. The Winterbourne View Serious Case Review highlighted the unlawful nature of restrictions imposed on people with learning disabilities in that service. It found that individual patient records gave rise to concerns because they did not accurately reflect the person's legal status under the Mental Health Act (MHA); nor did they give any indication as to whether the Safeguards had been considered.³

The decisions of the courts continue to develop mental capacity law, the meaning of 'deprivation of liberty' and practice. The health and social care system is currently changing. NHS primary care trusts will be abolished in April 2013, when local authorities will assume responsibilities as supervisory bodies for hospitals as well as for care homes.

How the Safeguards work in practice

The Safeguards must be considered in care homes and hospitals when the restrictions on a person's freedom, imposed in their best interests, may mean that they are deprived of their liberty. In addition to protecting the person's rights, the Safeguards can provide reassurance to staff that they are acting appropriately within the framework of the MCA, in a way that is proportionate to the risk of harm to the person. The following two examples illustrate this point.

Case study

Mrs A, care home resident



Mrs A has severe dementia and lives in a care home. She makes persistent and purposeful attempts to leave the home.

Staff are concerned for her safety if she was to leave, but also concerned not to restrict her rights and freedom any more than the minimum necessary for her safety.

The care home (managing authority) decides to ask the local social services authority (supervisory body) to consider whether Mrs A should be 'detained' in the care home under the Deprivation of Liberty Safeguards.

The local authority carries out a series of independent assessments (looking at the person's best interests and medical needs and including the person's family) and notes that Mrs A's medication is not being administered correctly – which could be exacerbating her anxiety.

The assessor recommends that the GP should review the medication and look into an alternative medication plan. The local authority agrees to authorise deprivation of Mrs A's liberty for a short period to allow time for these aspects of the care plan to be changed.

Case study

Mr B, care home resident



Mr B has learning disabilities, with behavioural difficulties including aggression when frustrated or anxious. He was admitted as an emergency to a local residential care home, after a violent incident at home – connected both to his problems and to his mother’s mental health issues and substance misuse.

The local residential home was unable to manage his behaviour, so he was placed in a specialist home 50 miles from his home. At this time he lacked capacity to consent to arrangements made by the home for his care.

He was missing his mum, who had been refused permission to visit, and made several attempts to leave the specialist home at bedtime before being brought back by staff in his pyjamas.

The home gave itself an urgent authorisation under the Safeguards to deprive Mr B of his liberty and requested a standard authorisation through the local social services authority. This request triggered a specialist assessment of Mr B’s best interests.

The best interests assessor found the level of restriction to be disproportionate to the risk and seriousness of harm to Mr B. She decided that this deprivation of liberty could not be authorised as it stood.

She informed the commissioners of the service that a serious dispute between Mr B’s mother and the unit should be mediated and, if unresolved, referred rapidly to the Court of Protection.

A formal best interests meeting was convened urgently. As part of this, contact between Mr B and his mother was reinstated, including facilitating visits from his mother to the care home. These visits were and are successful.

A care plan was agreed that worked towards moving Mr B into a supported living setting close to his mother’s home and care staff are working to give him increased daily living skills.

Mr B is no longer deprived of his liberty, but looking forward to a more independent lifestyle.

CQC’s role

CQC has a duty to monitor the operation of the Safeguards in England. A Code of Practice to the Safeguards sets expectations for CQC to monitor them through its existing programme of inspections, and to report annually.

Although CQC monitors the operation of the Safeguards, there are no enforcement powers associated with the role. If CQC finds that the Safeguards are not being used correctly, this could lead to action under the Health and Social Care Act. A number of the Health and Social Care Act regulations contain references to elements of the Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

CQC’s findings

Use of the Safeguards is increasing. CQC’s analysis of data from the NHS Information Centre shows that there were 11,393 applications to use the Safeguards in 2011/12, a 27% increase on the 8,982 applications made in 2010/11 and 59% higher than the 7,157 applications made in 2009/10, the first year of the Safeguards. More than half (56%) of all applications received resulted in authorisations being granted. This is similar to the 55% granted in 2010/11, but higher than the 46% granted in 2009/10.

In 2011/12, regional application rates ranged between 17 and 51 per 100,000 population. The average rate for England as a whole was

28
per 100,000

So far there has consistently been significant regional variation among care homes and hospitals in the way the Safeguards are used. Application rates by region have varied over the first three years of the Safeguards' operation. In 2011/12, regional rates ranged between 17 and 51 per 100,000 population. The average rate for England as a whole was 28 per 100,000.

Analysis of CQC's data from its monitoring activity shows that:

- **The umbrella legislation of the Mental Capacity Act (MCA) is not well understood or implemented in practice.** There is still a lack of understanding of the MCA among some staff in hospitals and care homes. If mental capacity is poorly understood, staff may be too quick to assume that people they are caring for lack capacity in respect of all decision-making (for example someone may lack capacity to make financial decisions but still be able to make decisions about their care or treatment). They may not look for ways to maximise people's capacity and decisions made on their behalf may not always be carried out within the best interests framework of the MCA. We know there have been instances where relatives and friends have been excluded from decision-making or asked to consent on behalf of the person in a way that is not lawful.
- **The implications of the Safeguards in practice are not easy to understand.** The Safeguards have only been in operation for three years, and so are still relatively new. In previous reports CQC has noted concerns about the complexity of the systems surrounding the Safeguards. This continued in CQC's inspection visits in 2011/12. There was also evidence that, on some mental health hospital wards, staff still did not understand the differences between the powers of the MHA and the Safeguards and how to decide which legislation is the appropriate one to use. This has implications for the way they are used, authorised and monitored and affects all parts of the system including hospitals, care homes, local authorities, primary care trusts and CQC. It may mean that people in hospitals and care homes are still not always treated or cared for in ways that respect their human rights – especially the right to liberty.
- **The use of restraint is not always recognised or recorded as such, and because of this it is not easy to monitor.** CQC is concerned that people's freedom sometimes appears to have been restricted without consideration of their capacity to consent to, or refuse, the restriction being recorded. Some examples showed little or no evidence of any attempt to maximise a person's decision-making capacity before resorting to restriction or restraint. The use of the phrase 'best interests' does not always appear to signal that there has been a process of best interests decision-making in accordance with the MCA.

Restraint is sometimes not recorded adequately, or not governed by policies to minimise its use. It can become routine, without ongoing consideration of less restrictive alternatives. For example, some inspection reports contained information about the use of restraint equipment, including ‘wander mats’ or ‘sensor mats’ – devices that alert staff when an individual gets out of bed. A number of these showed there was no evidence of appropriate capacity assessments or authorisation for the use of these.

- **There is wide variation in how local authorities carry out their functions as supervisory bodies.** Supervisory bodies hold both key decision-making (authorisation) and assurance roles in the Deprivation of Liberty Safeguards system. Because of the key role they play in this system, CQC identified a priority to improve access to information on how supervisory bodies carry out their responsibilities under the Safeguards. This thinking has been developed in consultation with external stakeholders. In 2012 CQC piloted a questionnaire among some supervisory bodies, asking about functions above and beyond those reported in the NHS Information Centre data. The pilot gave us useful insight into the variations in how supervisory bodies work and information on which to build our monitoring of supervisory bodies’ function in the future. This will focus on understanding the reasons for the variations.

We have seen examples of good practice in relation to best interests meetings, and instances where staff strived to listen actively to people using services and to involve them in decision-making

- **It is not clear whether people’s views and experiences of the Safeguards are being heard in care homes and hospitals.** In some services, there is evidence that people’s experiences and opinions of the Safeguards in practice are sought and acted on, as well as those of their relatives and advocates. We have seen examples of good practice in relation to best interests meetings, and instances where staff strived to listen actively to people using services and to involve them in decision-making. This included using non-verbal communication and watching reactions to situations.

However, there was very little evidence in CQC’s inspections of the involvement of people who use services and their relatives or friends in the processes of the Safeguards themselves. This is a significant omission: consultation with the ‘relevant person’ and their relatives and/or close friends interested in their welfare is a mandatory part of the assessment process.

CQC has a statutory duty under the Health and Social Care Act 2008 to listen to and consider the views expressed by people and carers. CQC piloted an approach to engaging people with experience of the Safeguards in 2011/12. In 2013 we will look at the outcomes of this project, in discussion with people who use services, and develop ideas on how to help take the work forward.

Conclusions and next steps

The MCA is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. There continues to be confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty. Recent court cases have ruled that there is no universal definition. Decisions can only be made on individual circumstances. The relationship between care, appropriate restrictions of liberty, the Deprivation of Liberty Safeguards and the wider MCA has become complex and potentially confusing.

The Safeguards cannot be understood without reference to the guidance on good practice that is to be found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the MCA. This is also true for CQC both in its role as regulator and in monitoring the use of the Safeguards. CQC recognises that ongoing improvements in its monitoring of the Safeguards, and the wider MCA, are vital tools to protect and promote the human rights of vulnerable people in health and social care.

CQC expects the following:

- **Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Safeguards.** Training in the MCA and the Safeguards is still patchy and not always reflected in improvements in practice. The use of care plans, recording of incidents, and gathering of feedback from staff, people who use services and their relatives all need to improve. Such practice needs to show that it complies with the principles of the MCA, and to demonstrate an understanding of when and how to explore a person's capacity to make a specific decision, and of best interests decision-making. Stronger links between managing authorities and local Independent Mental Capacity Advocate services may be one way of improving staff knowledge.
- **Care providers must implement policies that minimise the use of restraint.** Restraint should always be a 'last option'. Encouraging positive behaviours, with a view to minimising the use of restraint, can be explored in forums such as team meetings. CQC expects to find a greater understanding of the best interests and least restriction principles in the MCA and of the practice implications of the MCA's provisions on restraint. Staff need to be aware of when lawful restraint might be moving into a deprivation of liberty that requires specific authorisation.
- **Providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Safeguards.** CQC's inspectors saw examples of friends and relatives being excluded from best interests decision-making, contrary to the requirements of the law. Providers and commissioners must go to greater lengths to consult with relatives and friends as part of the process when using the Safeguards.

The Safeguards cannot be understood without reference to the guidance on good practice that is to be found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the Mental Capacity Act.

What CQC will do next

In line with its proposed strategic direction over the next three years, CQC intends to strengthen how it meets its responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's unique sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated strong support for this.

CQC will:

The shared objective must be ensuring that the Safeguards operate to maximum effect for the protection of vulnerable adults in health and social care settings

- **Improve inspectors' understanding of the Mental Capacity Act and the Safeguards.** We will continue the roll-out of training and resources for our staff on mental capacity and the Safeguards. We will work with stakeholders to make sure our guidance for providers and for CQC staff is up to date and reflects relevant case law.
- **Develop its work with local authorities in their role as supervisory bodies.** We intend to develop our methodology for gathering information on the operation of the Safeguards system from local authorities in the coming year. However, the success of this initiative as a monitoring tool will depend to a significant extent on the willingness of local authorities to collaborate with CQC. The shared objective must be ensuring that the Safeguards operate to maximum effect for the protection of vulnerable adults in health and social care settings.
- **Further develop ways to gather the experiences of people lacking capacity and their friends, families and carers.** We will carry out a new pilot study involving people's representatives and Independent Mental Capacity Advocates. This will help increase CQC's understanding of the experiences of people while they are subject to the Safeguards and help better understand the quality of service.
- **Continue to promote evidence of what works well.** We will highlight best practice and work to communicate this information to providers, staff and other stakeholders.

01

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 (MCA). The MCA is concerned with protecting and enhancing the human rights of people who might lack capacity to make their own decision. The aim of the 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.



The Safeguards can be used for adults aged 18 or over, who are in hospitals or care homes. People who benefit from the Safeguards typically include those with severe learning disabilities, dementia, or who have brain injuries.

People can also be deprived of their liberty in other care settings (such as their own homes, in supported living arrangements or in day centres) but only on the authorisation of the Court of Protection (a specialist court that considers personal welfare and financial decisions regarding people who lack capacity) following best interest considerations. Similarly young people under the age of 18 can be deprived of their liberty if authorised by the Court of Protection.

The reason the Safeguards were introduced

The case of Mr L



Mr L was profoundly mentally disabled and unable to consent to medical treatment. He was admitted to hospital by a psychiatrist without the use of the Mental Health Act, as he was thought to be fully in agreement with this course of action.

His carers challenged this admission because of the restrictions on his liberty that were applied to him once in hospital and because Mr L did not have the capacity to disagree with the restrictions. The reality was that he was not free to leave.

The case went to the European Court of Human Rights, which agreed that Mr L had been deprived

of his liberty within the meaning of Article 5 of the European Convention on Human Rights.⁵

The 'gap' that was identified was in the lack of safeguards for the admission and detention of people who appeared to agree but in fact lacked the capacity to consent or disagree.

There were no stated grounds for such action, no statement of purpose, no limits of time or treatment and no requirement for continuing clinical assessment. It was this gap that the Deprivation of Liberty Safeguards were designed to address.

The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment. This problem was brought to light in the late 1990s by the case of Mr L and became known as 'the Bournemouth Gap'.⁴

Why are the Deprivation of Liberty Safeguards important?

The Mental Capacity Act (MCA) provides a framework of law and good practice to support individual decision-making about health and social care. It is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. The MCA provides guidance to people who need to make decisions on behalf of someone else. It sets out the principles that should guide such decisions, including the requirement to act in the person's best interests and to achieve the desired outcome in ways that are least restrictive of the person's rights and freedom of action.

⁴ HL v United Kingdom (2005) 40 EHRR 761

⁵ Article 5(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ... (e) the lawful detention... of persons of unsound mind...

The Safeguards provide a system of protection for people who are unable to make decisions for themselves about the arrangements for their care or treatment. This system requires authorisation to be given when people are deprived of their liberty. The scheme for making authorisations ensures it takes place only when it is in their best interests, is a proportionate response to the likelihood of harm to that person and the seriousness of that harm, and there is no less restrictive option that can be identified for making sure they get the care and treatment that they need.

In addition to protecting the rights of the vulnerable individual receiving care, the Safeguards can provide reassurance to staff that they are acting appropriately within the framework of the MCA, in a way that is proportionate to the risk of harm to the person. The examples on pages 4 and 5 illustrate this point.

There have been high profile failures in health and social care which include deprivation of liberty. The Winterbourne View Serious Case Review highlighted the unlawful nature of restrictions imposed on people with learning disabilities in that service. The Review found that individual patient records gave rise to concerns in that they did not accurately reflect the patients' legal status under the Mental Health Act, nor did they give any indication as to whether the Safeguards had been considered.⁶

The Safeguards provide a system of protection for people who are unable to make decisions for themselves about the arrangements for their care or treatment

CQC's role in monitoring the Safeguards

The Care Quality Commission (CQC) has a duty to monitor the operation of the Safeguards in England.⁷

CQC also has the ability, under the same legislation, to provide advice and information to the Secretary of State on the use of the Safeguards in England. A Code of Practice to the Safeguards sets out expectations for the monitoring role, and says CQC should monitor the Safeguards through its existing programme of inspections, and report annually.⁸

Because CQC has the task of monitoring the Safeguards, and of monitoring the operation of the MHA, it is one of 18 bodies that form the UK's National Preventive Mechanism under OPCAT (the United Nations Optional Protocol to the Convention Against Torture). The preventive mechanism performs the UK's obligations under that treaty to prevent torture and other cruel, inhumane or degrading treatment or punishment. This additional obligation underlines the seriousness that depriving people of their liberty may have in health and social care settings.

Although CQC monitors the operation of the Safeguards, there are no enforcement powers associated with the role. If CQC finds that the Safeguards are not being used correctly, this could lead to CQC taking action under the Health and Social Care Act 2008. A number of the Health and Social Care Act regulations contain references to elements of the Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

⁶ Winterbourne View Serious Case Review – p126 <http://hosted.southglos.gov.uk/ww/report.pdf>

⁷ The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009. See <http://www.legislation.gov.uk/ukdsi/2009/9780111474242/contents>]

⁸ MOJ (2008) Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act Code of Practice London: TSO

Applications year on year

There has been a year-on-year increase in the number of applications for the Safeguards since their first introduction

+27%

on 2010/11

+59%

on 2009/10

Advisory Group

CQC set up an advisory group of people with expertise in the area of the MCA and the Safeguards, to advise us on the production of this report. CQC is grateful for the support it has received from the expert members of the group. It has been a particularly useful mechanism for testing ideas, sharing information on the operation of the Safeguards in practice and developing more collaborative approaches to CQC's monitoring role. CQC intends to continue with this forum, and will explore ways to include the perspective of people subject to authorisation under the Safeguards and their representatives.

The membership of the group can be found in appendix C.

The context for CQC's monitoring

This is CQC's third annual report on the Safeguards. The two previous reports noted that there was a lower than predicted number of applications to supervisory bodies to begin with, but that this number rose during that first year and the second year of operation. Numbers have continued to rise, despite a fall in the first quarter of 2012 (the first seen, and possibly linked to case law developments). In previous reports we noted concerns about the complexity of the systems surrounding the Safeguards. CQC continued to find evidence of this concern through its inspection visits in 2011/12. There is also evidence that on some mental health hospital wards, staff remain unclear about differences between the powers of the MHA and the Safeguards and how decisions on the appropriate legislation to apply should be made in practice.

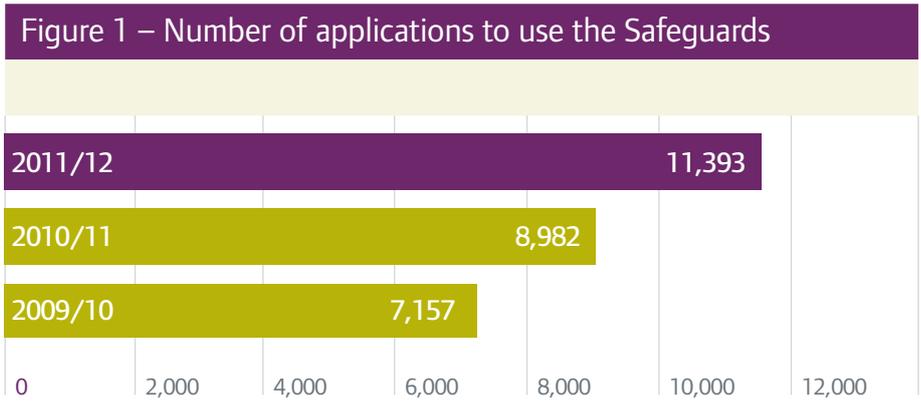
The debates and decisions of the courts continue to develop the whole area of mental capacity law, the meaning of 'deprivation of liberty' and practice. A summary of developments in case law in 2011/12 can be found in appendix A. It includes cases referencing decision-making by local authorities, the meaning of deprivation of liberty and other matters.

Any concern identified through a check on the operation of the Safeguards is considered as part of CQC's ongoing reviews of compliance with the Health and Social Care Act for the service provider concerned. Where there has been a breach of the relevant regulations, CQC takes appropriate action and enforcement as necessary. Appropriate action has been taken in respect of all the specific concerns raised in this report.

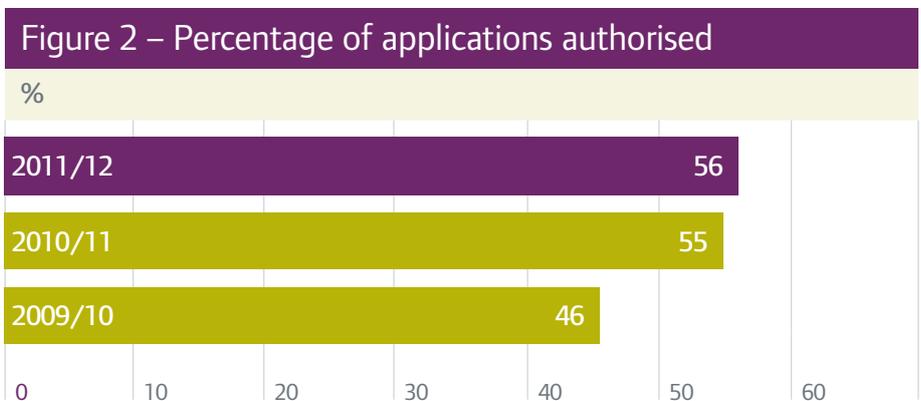
Use of the Safeguards

There has been a year-on-year increase in the number of applications for the Safeguards since their first introduction. There were 11,393 applications in 2011/12, which represents a 27% increase on the 8,982 applications in 2010/11 and a 59% increase on the 7,157 applications in 2009/10, the first year of the new Safeguards (figure 1).⁹

⁹ http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/dols2011-12/mca_dols_eng_2011-12_3rd_rep.pdf



Over half (56%) of all applications received resulted in authorisations being granted. This is a similar proportion to the 55% granted in 2010/11, but higher than the 46% granted in 2009/10 (figure 2).

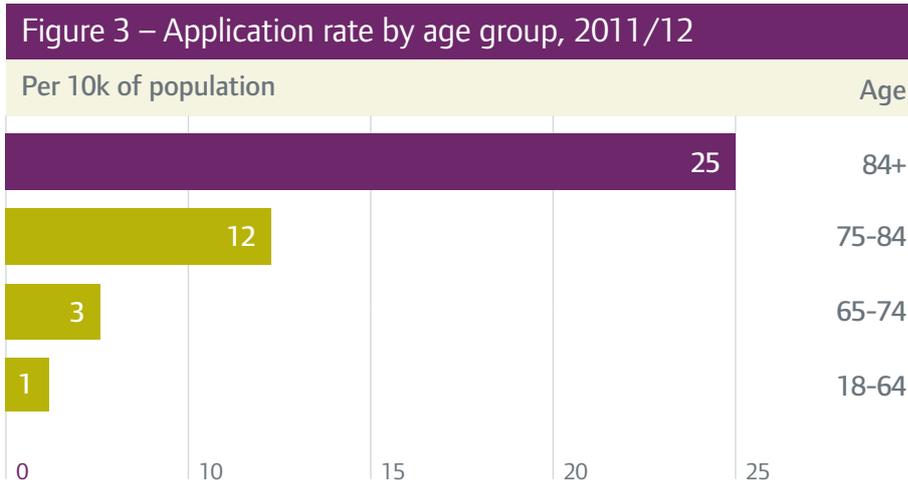


Dementia accounted for 53% of all applications, and this is reflected in the age profile of people who are the subject of Safeguards applications

The number of people subject to a standard authorisation at the end of the quarter had increased each quarter since the Safeguards were introduced in April 2009, from 536 at the end of June 2009 to 1,976 at the end of December 2011. This was then however followed by the first fall in numbers, of 16%, which is possibly linked to case law.

Dementia accounted for 53% of all applications, and this is reflected in the age profile of people who are the subject of Safeguards applications. Fifty-eight per cent of applications related to people aged over 74, and the population-based rate of applications was much higher for over 74s and over 84s. For the over 84s the application rate was 25 in 10,000. This compares with 12 in 10,000 for 75-84 year olds, 3 in 10,000 for 65-74 year olds and just 1 in 10,000 for 18-64 year olds (working age adults) (figure 3).

Local authorities received a higher proportion of applications (72%) than primary care trusts (PCTs) who received 28%



There were wide variations in population based application rates by region. The East Midlands had the highest rate of applications, at 51 per 100,000, and London had the lowest rate at just 17 per 100,000. These compare to a rate for England as a whole of 28 per 100,000.

Local authorities received a higher proportion of applications (72%) than primary care trusts (PCTs) who received 28%. They also granted a higher proportion of authorisations than PCTs (57% compared with 52%). Clearly someone in a care home is more likely to have a Safeguards authorisation granted than someone in a hospital.

There were 2,583 reviews held, but we have no information about outcomes.

Wherever possible, applications for deprivation of liberty authorisations should be made before the deprivation of liberty begins. When this is not possible, an urgent authorisation can be given which will make the deprivation of liberty lawful for a short period of time. The Code of Practice to the Safeguards sets out the circumstances in which a managing authority can give itself an urgent authorisation.¹⁰

Of 3,712 standard authorisation requests that followed from the managing authority having given itself an urgent authorisation for up to seven days, because it thought that a deprivation of liberty was actually taking place already (or would within the period allowed for assessments and decisions for a standard authorisation, 21 days), 66% came from care homes, and 34% from hospitals. Fifty-one per cent were granted and 49% were not granted.

¹⁰ Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice TSO 2008 para 6.1

02

Monitoring use of the Safeguards through inspection of hospitals and care homes

CQC inspectors monitor the operation of the Deprivation of Liberty Safeguards as one aspect of broader inspections of settings in which the Safeguards may be authorised – that is care homes and hospitals. Sometime we also raise issues relating to the Safeguards through our dedicated programme of visits to meet patients detained under the MHA. In this section we present an analysis of our findings from a sample of these visits. For the methodology we used, see appendix B.



During 2011/12 CQC took a number of steps to strengthen the relevant skills and knowledge of compliance inspectors in order to promote a wider and more consistent understanding of the MCA in general and the Safeguards in particular. We devised an e-learning package for inspectors, and related learning has been included as an important and integral part of both permanent and bank inspector induction courses. We have also taken steps to improve the awareness of CQC staff who assess applications for registration.

We acknowledge that CQC still has work to do to ensure that all relevant inspectors have a sufficient level of understanding of the MCA to support a consistent and effective approach to monitoring the use of the Safeguards.

2.1 Staff training and awareness

Key points

- The MCA legislation is not well understood or implemented. Because of this, staff may be too quick to assume that people lack the capacity to make any decisions. Also staff may not try to maximise people's capacity, or carry out decisions within the best interests framework of the MCA, because they don't understand the legislation.
- There is some excellent practice in the system, particularly where providers have recognised the importance of the MCA by having a lead staff member or a specific MCA team.
- Levels of training and awareness are still highly variable. Where there is some, it is not always translated into practice, even at the most basic level.
- Training on the MCA in general, and the Safeguards in particular, is often combined with other unrelated training (for example, moving and handling, infection control or fire safety). This approach fails to acknowledge the importance of the MCA.

From the analysis of the inspection reports a number of key themes arise relating to staff training and awareness. These are summarised below.

Variation in levels of training

A number of reports distinguished between training for different levels of staff. For example in some cases it was reported that managers, 'senior staff', 'trained' or 'qualified' nurses had received training, but other types of care staff had not. This variation suggests that while some form of Safeguards and/or MCA training is being provided it is not consistent in terms of the level of training, and in whether it is recognised as mandatory for all or seen as for 'specialist' or 'senior' staff.

The following example described a tiered approach to training:

“ *Managers undertook the local authority training linked to local safeguarding procedures, and they and the registered nurses received additional training about the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). Care workers benefited from some training in this area, to enhance their appreciation of the risk management and human rights aspects of the job they do, within their safeguarding training. The provider told us it had been a priority to provide the specialist training to registered staff, and that arrangements had been made for care workers to receive more in-depth Safeguards and MCA training in December 2011.”*

Evidence from one inspection shows the risks associated with patchy training: the registered manager had a good understanding of the Safeguards and the MCA but had recently resigned. Senior managers and the staff training record both confirmed that the other staff had not received any training on the topics; this meant there was a gap in the required knowledge and awareness that needed to be addressed.

Lead person or team

In some examples, inspectors referred to the presence of a lead or a link person to help embed the principles of the MCA.

“ *A senior member of staff told us that there is a lead in the hospital for mental capacity assessments. We saw a pocket-sized quick reference guide to the Mental Capacity Act available on some wards which outlined the principles of the act, the test of capacity, how to assess capacity, and best interests decision making.”*

However, there were examples of when a reliance of one member of staff to provide guidance on the MCA and Safeguards was not an appropriate approach.

In one report, the manager had said that many staff had not received training because the previous trainer had retired and not yet been replaced, leading to a lack of awareness of the Safeguards and staff being unclear about the policies and processes.

A senior member of staff told us that there is a lead in the hospital for mental capacity assessments. We saw a pocket-sized quick reference guide to the Mental Capacity Act

However, in another example, the organisation had a designated group of professionals responsible for the Safeguards, and one of the senior members of staff attended quarterly meetings organised by the local MCA Lead.

Policies and documentation

In some instances, there was good practice in relation to policy and documentation concerning the Safeguards and/or the MCA. For example, the inclusion of information on MCA and the Safeguards in safeguarding policies, and clear procedures for assessing capacity, gaining consent and reporting abuse.

There were examples of good care documentation, such as having clear and accessible capacity and consent forms for all patients.

There were good examples in relation to disseminating information. These included checklists used for consent and capacity, information displayed in staff offices, information in employee handbooks, and booklets available in communal areas



Information and awareness

There were examples of positive practice such as the display of information about the Safeguards and/or MCA within wards, and the provision of information to patients and relatives/carers.

There were good examples in relation to disseminating information. These included checklists used for consent and capacity, information displayed in staff offices, information in employee handbooks, and booklets available in communal areas.

In addition to training, there were examples of other approaches used to increase awareness of issues, which included having a dedicated section on the staff intranet, leaflets as part of staff inductions, and copies of the Codes of Practice to the MHA and the Safeguards being readily accessible on wards.

Some examples showed additional routes for sharing knowledge about the Safeguards and/or MCA such as managers passing on information through staff meetings or organisational briefings. One report stated that some staff had received training and that this was available to other staff "should the need be identified", while others indicated that staff had been trained but that this was out-of-date or due to be updated.

Concerns about levels of awareness of the Safeguards/the MCA were highlighted through discussions with staff, particularly in relation to voluntary patients (also known as 'informal patients') who were on wards alongside patients detained under the MHA. This theme is also raised in the sections of this report on assessments, and the use of restrictions/restraint.

“ *Staff on duty did not know about DoLS safeguards. Qualified staff did not know what authority they had for giving medication to an incapacitated patient who is informal. The Commission is very concerned at the apparent lack of knowledge of staff of the MCA and the Safeguards. The Commission asks whether training has been provided and how this training is put into practice. The Commission asks whether the unit is satisfied that none of their informal patients are subject to de facto detention.”*

“ *A patient was listed on the nurses' office whiteboard as being subject to 'section 5'. The ward manager included this patient among the detained patients when providing the Commissioner with the number of detained patients on the ward. On further investigation, however, it transpired that the patient was not detained under section 5 of the Mental Health Act, but, rather, lacked capacity to consent to stay on the ward and was being treated in her best interests under the Mental Capacity Act (MCA). 'section 5' referred to that section in the MCA. One member of staff described the patient as being 'on section 5 of the MCA'. When the Commissioner explained that no one can be 'on' a section 5 of the MCA, and that section 5 does not authorise a deprivation of liberty or a detention, the member of staff said that the patient was 'sort of detained'.”*

Impact of training

The impact of training and the extent to which it enhances the knowledge, skills and behaviours of staff longer term is something that is not possible to analyse from the report extracts.

However, there was evidence to show where training in MCA and the Safeguards had occurred and how it was applied:

“*Staff had received training on the Mental Capacity Act and on Deprivation of Liberties and how it impacts on their work. Staff could describe examples of where they had put this training into action. For example with people who wished to smoke in the home and for those people who had their movement restricted for safety reasons with the use of bed rails and electronic key pads. These areas were well documented in people’s care plans and had accompanying risk assessments to ensure that the risk in these activities was minimised without unduly infringing on people’s human rights.*”

However, one instance showed that although the majority of staff had completed Safeguards/MCA training, there had been numerous safeguarding incidents that had occurred and had not been reported and recorded. This highlights the need for organisations to have robust policies and procedures in place alongside training.

“*People who used the service were not always protected from harm or abuse. Some staff had not undertaken training in relation to using physical interventions, safeguarding adults, Mental Capacity Act or Deprivation of Liberty, while many incidents had not been reported appropriately.*”

“Records showed us that there were high numbers of accidents/incidents occurring, daily notes showed us that these were not always reported as they should be and very few notifications had been submitted to CQC. We saw that people had received injuries and required treatment. Some incidents had involved allegations made about staff and others had involved patients being physically and verbally aggressive. However, only four of these incidents had been referred to the Safeguarding team. We looked at five staff files and the training schedule; this told us that 20 out of the 23 care staff had undertaken training in relation to safeguarding adults. Eighteen of the 23 had completed the Mental Capacity Act or Deprivation of Liberty training. However, numerous incidents had occurred and these were not reported or recorded as they should have been.”

X
Some staff had not undertaken training in relation to using physical interventions, safeguarding adults, Mental Capacity Act or Deprivation of Liberty, while many incidents had not been reported appropriately.



Making improvements

There were examples where organisations had made improvements in staff training since previous inspections.

“It was identified during our visit in April 2011 that staff had not received training for the Mental Capacity Act and Deprivation of Liberty Safeguards, and were not aware of how this legislation affected people, including making decisions about future care. All staff have now received this training and we spoke to staff about their understanding of capacity and the decision-making process.”

2.2 Process of assessments, applications and authorisations

Key points



- There is some confusion between best interests decision-making in general and the best interests assessment process under the Safeguards.
- Staff do not always understand the relationship between consent and capacity. In good practice, staff should seek valid and informed consent for care or treatment. This means explaining the care, and what agreeing to or refusing it will likely mean for the person. This process should happen with everyone when consent is required.

As in last year's analysis of inspectors' findings regarding the Safeguards, examples of both positive and poor practice were identified in relation to assessments of mental capacity and Safeguards assessments. From the analysis of the inspection reports a number of key themes arise relating to assessments, applications and authorisations. These are summarised below.

There is some confusion between best interests decision-making in general and the best interests assessment process under the Safeguards



Assessments

Examples of positive practice included where mental capacity assessments had been carried out for all service users, and in some cases these involved multi-disciplinary teams, consultant psychiatrists, or a Second Opinion Appointed Doctor (SOAD).

Some reports described the involvement of external professionals such as Independent Mental Capacity Advocates, community psychiatric nurses and registered mental health nurses in carrying out capacity assessments.

In some instances, mental capacity was routinely being assessed as part of initial assessment, but review and further assessments were lacking in relation to day-to-day decisions. For example, in one organisation all the service users had an overall capacity assessment recorded in their care plans, but they did not have further assessments for individual decisions, such as their ability to consent to treatment.

This highlights the importance of ensuring that capacity is assessed if appropriate both at admission, and periodically after admission, to ensure that individuals are having their rights protected in every situation.

One example of positive practice was where assessments were carried out before flu vaccinations as part of the decision-making process. Another instance showed that mental capacity assessments were carried out for 'day-to-day living' for issues such as opening post, medication, road safety, and reading, and that these were regularly reviewed.

“ *We saw that MCA assessments were completed for all day-to-day decisions and then these were linked to the individual's care plans to record how decision-making was managed for the person.”*

Some examples showed that mental capacity assessments were incomplete, or had not been reviewed even when people's circumstances might have changed. Other issues included inconsistency in gaining consent. For example, in one case the person was variously documented across different records as refusing consent, providing consent, and as not having capacity:

“ *One person we case tracked had some consent forms where it was documented as refusing to consent; other consent forms had been signed. This individual was a voluntary patient who was no longer under section. However, it was also noted this individual was deemed not to have capacity. This did not appear to have been addressed with a Deprivation of Liberty assessment.”*

Some examples showed that mental capacity assessments were incomplete, or had not been reviewed even when users' circumstances might have changed. Other issues included inconsistency in gaining consent



Regarding mental capacity, CQC notes that it can be difficult to decide whether capacity should be routinely assessed in a specific setting (particularly in settings where patients are regularly detained). Fluctuating capacity, or different levels of capacity for different decisions, does not in itself mean that use of the Safeguards is necessarily indicated. While a lack of capacity to consent to conditions of restraint is a necessary precondition for considering whether a person is deprived of their liberty, the decision must also take account of the conditions in which restraint is authorised under MCA sections 5 and 6. Staff in mental health settings must also be clearly aware that the Safeguards do not authorise treatment: treatment decisions for people lacking capacity to give consent, which fall outside the Mental Health Act, must be made as best interests decisions under the MCA.

Reports also referred to the quality and depth of assessment. In a number of examples, assessments were described as "insufficient" or "inconsistent". In one instance, the report noted that there was no evidence that a two-stage mental capacity assessment had been carried out for an individual, but a relative had signed a form to confirm that they no longer had capacity:

“ *We checked the care plans of three people for evidence of involvement of the person using the service and their relatives. In one care plan we saw evidence that a relative had signed appropriate consent forms for installation of specialist equipment. A relative had also signed a form to confirm that the person using the service no longer had capacity to make their own decisions. However we did not see any evidence that the service had carried out a two stage assessment of this person's capacity. This is a requirement under the Mental Capacity Act. The manager thought that this had been done but could not find the assessment during our visit.”*

Documentation

Where assessments were described, positive practice found by inspectors included having: Safeguards checklists; clear documentation in care plans; best interests meetings with the recorded involvement of professionals and relatives; and regular reviews of capacity.

“ Documentation on files sampled included assessments of mental capacity. Also a checklist of conditions to be satisfied, guiding staff to know when to make a referral to the local supervisory body for authorisation to deprive a person of their liberty. This decision would be made in their best interest in accordance with the Mental Capacity Act and reviewed in line with appropriate guidelines.”

However, in some cases, even where assessments were being carried out, the necessary records and documentation were not always being fully completed. For example:

“ People were being well supported by the staff when they did not have capacity to make their own decisions. We heard about how the Mental Capacity Act was being used effectively to assess if a person was able to make their own decisions and, if they were not, how the systems in place worked to make good decisions on their behalf. However there was some poor recording about people’s decisions about whether they were to receive emergency treatment or not.”

In some cases it was reported that there were no records of MCA assessments being carried out.

“ We could not find evidence of mental capacity assessments on file. Mental capacity should be assessed to ensure that people who are capable of making decisions do not have them made on their behalf.” “Where people did not appear to have capacity to make decisions and choices, we did not see any evidence to confirm that staff had followed correct processes such as the use of best interests assessments and mental capacity assessments.”

Where assessments were described, positive practice found by inspectors included having: Safeguards checklists; clear documentation in care plans; best interests meetings with the recorded involvement of professionals and relatives; and regular reviews of capacity



Appropriate legislation

The reports indicate that the different, specific and formal nature of capacity and best interests assessments within the Safeguards process is not clearly differentiated from the more general MCA in the understanding of both some staff and some inspectors.

In some instances, it was shown that Safeguards assessments would only be completed where patients were seeking to leave the ward, although another example showed that in these situations the staff were inclined to use a section under the MHA, due to the time needed to complete a Safeguards application and authorisation.

“*Few DOLS Officer assessments are carried out and although the relevant personnel are present in the hospital, the time taken to complete the assessment is not within a time frame to respond to deal with a patient wishing to leave. Staff tend to use a section to resolve enduring capacity issues.*”

The evidence suggests that on some wards there may be a lack of clarity concerning the appropriate legislation to apply



This demonstrates lack of knowledge of both Acts. If a person is a ‘mental health patient’ under the MHA and resisting any aspect of their treatment, the MHA is the lawful route to protect their rights. If any managing authority finds it is necessary to deprive a person of their liberty they can give themselves an urgent authorisation to legalise the situation for up to seven days while seeking a standard authorisation.

The evidence suggests that on some wards there may be a lack of clarity concerning the appropriate legislation to apply. In one MHA Commissioner’s report they had major concerns that ‘Guardianship Orders’ (a process under the MHA that appoints a ‘guardian’ to make some decisions on behalf of a person with a mental disorder) were being used explicitly to authorise the deprivation of liberty of individuals, when legally they cannot be used in this way:

“*Of the 10 Guardianship records, there are major concerns that at least six Guardianship orders are or were being used as a legal framework explicitly to authorise the deprivation of liberty of incapacitated patients in care settings... The local authority should review each of these six cases and decide whether Guardianship is the most appropriate legal power to be using (or to have been used).*”

Voluntary patients

Another theme identified was poor practice in services where voluntary (informal) patients were on wards alongside patients detained under the MHA. In some instances voluntary patients were not being given capacity assessments where appropriate, and their rights were being restricted alongside those of the detained patients. This seemed to be due to a lack of staff knowledge and awareness concerning the differences between the MCA and MHA. For example:

“*Two members of nursing staff who were spoken to did not appear to know the difference between the Independent Mental Capacity Advocacy and Independent Mental Health Advocacy service, and there appeared to be some confusion in their understanding of the difference between DoLS and general safeguarding issues.*”

Making improvements

In some organisations it was clear that practice concerning assessment had improved since previous inspections. In some cases this was through increased assessments, and in others due to changes in documentation or awareness-raising of MCA/Safeguards issues among staff. For example one instance showed how the provider had introduced documentation to record capacity as part of the electronic records system:

“ We talked to staff nurses on both wards about the new capacity recording form and all felt the new approach was much better because there was a clear record of a patient’s capacity and it was easy to find on the system. A nurse on ward explained the approach to recording capacity was a ‘lot better now’ and ‘doctors were doing them [capacity assessments] regularly and in a very short period of arriving [for admission]’. They also thought the form was ‘well structured’.”

2.3 Use of restrictions or restraint

Key points



- People’s freedom sometimes appears to have been restricted without consideration of their capacity to consent to, or refuse, the restriction being recorded.
- There is confusion among care staff about the basic MCA requirements relating to the use of restraint. The use of restraint is not always recognised or recorded properly. Because of this it is not easy to monitor.
- The use of restraint can become routine when there is a lack of understanding and proper governance. It can also be hard for staff to gauge whether restraint is proportionate and in someone’s best interests.
- There have been examples of blanket restrictions in all types of settings, which is often distressing for people. Their use did not generally appear linked to individualised person-centred care planning.

It is of concern that people’s freedom sometimes appears to have been restricted without recorded consideration of their capacity to consent to or refuse the restriction. Some examples showed little or no evidence of any attempt to maximise a person’s decision-making capacity before resorting to restriction or restraint. The use of the phrase ‘best interests’ does not always appear to signal that there has been a process of best interests decision-making in accordance with the MCA.

Typical examples of the use of restrictions or restraint relating specifically to the Safeguards and/or the MCA referred to in the reports included:

Locked doors/key pads: There was evidence that people were being restricted by locked doors. This was a particular issue in rehabilitation units and hospitals where people are detained under the MHA, and was mentioned in several reports.

“We noticed staff accompanying patients off the ward and patients being prevented from leaving the ward. There was no evidence anywhere to suggest that capacity or Deprivation of Liberty Safeguards had been considered for non-detained patients who are prevented from leaving the ward for their own safety.”

Smoking restrictions: In some cases patients were having restrictions placed on smoking without consideration of their capacity to decide. One report said that an individual was recorded as having a “smoking management plan” in place in their best interests, but there was no evidence of a mental capacity assessment or formal best interests decision-making process to decide this.

Bed rails: A small number of reports referred to the use of bed rails, and there were cases where these were in place without the appropriate risk assessments or consent from patients, or representatives of patients lacking capacity. As one described:

“Consent for bedrails was not always signed for by patients with capacity, or the representatives of those people lacking capacity. Bed rails could be viewed as a form of restraint but, there was no evidence that DOLS applications or best interest meetings had been held to support their use.”

Note: Relatives cannot give consent for any restrictions unless they have health and welfare Lasting Power of Attorney. The decision should be a best interests one, as indicated. Bed rails are rarely identified as a deprivation of liberty.

A number of key themes arise relating to restraint. These are summarised below.

In some cases patients were having restrictions placed on smoking without consideration of their capacity to decide



Assessment

There were examples of organisations operating restrictions, which had appropriate assessments in place, such as locked door policies.

There were other instances of positive practice regarding restrictions and restraint. For example, one showed that a best interests meeting had been held to agree the appropriate level of restraint for an individual to ensure hygiene after incontinence.

However, in some cases restrictions had been put in place without proper assessments being made. There were references to situations where patients were restricted but had not been assessed and the need for best interests decisions or Safeguards applications did not appear to have been considered:

“ *We asked whether mental capacity assessments had been undertaken or best interests meetings held to support how decisions had been made about the restrictions placed on patients. We were told these had not been carried out.*”

There were examples showing where people were restricted from entering or leaving a unit without asking staff, and where staff had been locking people’s bedroom doors. In some cases these restrictions were being used where an overall mental capacity assessment had been carried out to determine a patient’s placement in the service, but capacity had not been assessed in relation to understanding why their movements are restricted. There were references to best interests decision-making, but inspectors did not make explicit references to whether less restrictive options had been sought:

“ *We also observed that the dividing door to the male unit was permanently closed and could only be opened by staff. This system meant that people living at [X] could not leave or enter the unit area freely unless they asked staff to let them in or out. This system is a deprivation of their liberty, and could lead to an abuse of power by staff. People with learning disabilities may lack capacity and therefore the ‘best interests’ of these people under the Mental Capacity Act should be assessed at a best interests assessment. Enforcing gender separation by means of locking the bedroom wing is disproportionate to the risk posed, and could be better addressed by appropriate staff deployment. The provider’s representative was asked to submit applications for best interests assessments for locking people’s bedroom doors. We have been informed that a number of these had been submitted to the placing authorities for assessment.*”

There were examples showing where people were restricted from entering or leaving a unit without asking staff, and where staff had been locking people’s bedroom doors

Some reports contained information about the use of restraint equipment, including ‘wander mats’ or ‘sensor mats’ - devices that alert staff when an individual gets out of bed. A number of these showed there was no evidence of appropriate capacity assessments or authorisation for the use of these. Other examples mentioned the use of bed rails and wheelchair lap belts, but practice was mixed in terms whether risk assessments were being conducted and best interests meetings held in relation to individuals lacking capacity but considered to need such restraints.

There was one instance where an organisation had been using a ‘quiet room’ with a surveillance camera, without consultation with professionals and relatives, or consideration of best interests issues, mental capacity or the human rights of people using services.

Monitoring and recording

There was evidence that incidents of restraint were being well recorded, and there were many references to the provision of appropriate training on restraint and de-escalation techniques, although not specifically in relation to the Safeguards or mental capacity.

There were also examples of poor practice in the monitoring and recording of the use of restrictions or restraint, as well as an inconsistency between reported and actual practice. As one example showed:

“ *[Staff] told us that where applicable, they only used DoLS when it was in the best interests of the person who used the service and in accordance with the MCA. However, there were restrictions in place; for example, people...did not have access to the kitchen which was always locked. Systems in place..., did not demonstrate that this had been considered within their best interests assessments.”*

In other reports, patients had been restricted in their best interests without sufficient record or evidence of how these decisions had been made.

Understanding of the Safeguards

There was some evidence of staff confusing the MHA and MCA in written records. For example in one case, a patient was listed as ‘detained’ on the ward whiteboard, but further investigation found that they were not detained but were lacking capacity and subject to treatment in their best interests under the MCA.

“ *This evidences a worrying lack of understanding by all staff of the Mental Capacity Act, the Deprivation of Liberty Safeguards and how they relate to the Mental Health Act. The Commissioner is concerned that the patient’s Article 5 right to liberty under the Human Rights Act may have been breached during their stay on the ward, and there is a risk that this may still be happening and may happen in the future. The staff do not appear to understand the limits of what may be done under the MCA in a person’s best interests.”*

There was evidence that incidents of restraint were being well recorded, and there were many references to the provision of appropriate training on restraint and de-escalation techniques



In some cases organisations that were operating a locked door policy were shown to have appropriate Safeguards assessments in place, but in others it was reported that they had not made use of the Safeguards and this was identified as an area for improvement. Such findings highlight that there is sometimes confusion both by inspectors and within organisations about what may constitute a deprivation of liberty and about how restrictions can be made lawful, such as assumptions that family members can authorise restraints.

Availability of information

Some organisations had positive processes and practices to make patients aware of their rights, for example locked door pictures to explain that patients can ask to leave, leaflets, and individual key fobs for voluntary patients.

The use of restrictions and restraint in locked wards for voluntary (informal) patients was a key issue



However, there were also cases where voluntary patients had spoken to MHA Commissioners directly and stated that they did not think they were allowed to leave. The importance of regularly reminding voluntary patients of their right to leave, particularly where they may lack capacity was raised in reports. As one MHA Commissioner pointed out, these patients “may have to have the extra safeguard of being reminded on a regular basis”. Notices were thought to be an effective way of doing this.

Restrictions on voluntary patients

The use of restrictions and restraint in locked wards for voluntary (informal) patients was a key issue, as it was in the 2010/11 report.

However such practices were not always in place and there were a greater number of reports in which MHA Commissioners expressed concerns about whether voluntary patients were aware of their ability to leave, as this could constitute a ‘de facto’ deprivation of liberty:

“All nine patients were informal and thus should be free to come and go from the ward. However there is a coded lock on the door and the code was not on display for patients who have capacity. This could be seen as a deprivation of liberty matter. We discussed with staff the need to display the code or to inform all patients when a patient related issue means that the code cannot be displayed.”

In some instances, the lack of information about locked doors was accompanied by more active forms of restriction. In one case a MHA Commissioner reported that when asked about allowing voluntary patients to leave, the hospital manager had stated they would use holding powers under the MHA to prevent them. This example of de facto detention was raised as a serious concern.

Improvements

In several cases organisations were asked to provide information for voluntary patients and to seek Safeguards authorisations where necessary.

Some had responded and the reports showed this. A number had taken action to display information about locked doors, as well as having made Safeguards applications and having sought to improve staff training where appropriate.

One example showed an improvement in the use of restrictions since a previous inspection. The organisation had since worked to include mental capacity assessments for patients when making day-to-day decisions. One patient was assessed as not having the capacity to decide to leave the hospital, and there was documentation showing that the options of using the MCA or the MHA had been looked at in order to find the least restrictive intervention. A best interests decision was therefore made:

“During a previous inspection visit ... in September 2011 we found that the service was not assessing patients’ capacity under the Mental Capacity Act 2005 and there was no documentation that demonstrated the best interests of the patient were promoted, as some restrictions were in place for smoking and leaving the building. Following the previous inspection the Trust had submitted an action plan detailing how patients would have their capacity assessed in accordance to the principles of the Mental Capacity Act. During this visit we saw evidence to confirm that patients were having their capacity assessed when making various decisions and this was being carried out in accordance with the Mental Capacity Act.”

2.4 Involvement of people who use the service and relatives in decision-making

Key points



- In some services, peoples’ experiences and opinions have been heard, as well as those of their relatives and advocates. Good practice includes use of best interests meetings and involvement in decision-making.
- However, there is very little evidence of the involvement of people who use services and their relatives/friends in the processes of the Safeguards themselves. This is a significant omission: consultation with the ‘relevant person’ and with their relatives and/or close friends interested in their welfare is a mandatory part of the assessment process.

A number of key themes arise relating to the involvement of people who use the service and relatives in decision-making. These are shown below.

Decision-making and best interests

There were some examples of positive practice in relation to best interests meetings, and staff strived to listen actively to people using services, including through using non-verbal communication and watching reactions to situations.

The involvement of people using services and their relatives was highlighted in relation to the outcomes of diagnostic tests, the use of restrictions or restraints, and in decisions about treatment. There was some evidence of treatment decisions being reviewed in collaboration with healthcare professionals, for example hospital consultants and GPs, and family members. Some reports referred to multi-disciplinary meetings.

For example, in one case a best interests meeting was held to make decisions about the appropriate level of restraint to use for an individual - this involved healthcare professionals and the person's partner and children.

Concerns about poor practice regarding involvement in decision-making were highlighted in connection with low staff awareness and a lack of training in relation to the Safeguards and the MCA:

“*Staff had not received training and were unaware of the Mental Capacity Act 2005. They were unaware of the Deprivation of Liberty Safeguards and no referrals for Deprivation of Liberty assessments had been made on behalf of people using the service. There was no information available to demonstrate that “best interest meetings” had been held on behalf of people or decisions made using this framework. We saw examples of where people’s movements were restricted, for example at times the kitchen door is locked. One member of staff also told us people are “taken to their room” when they were agitated. There were no records detailing how these decisions were made, if other options had been explored, and whether people living in the home were involved in these decisions.*”

Also noted was a lack of detail in care plans regarding how individuals had been involved in decision-making. In one case, such involvement was found to be lacking, even though the organisation had worked well to provide information about the Safeguards and mental capacity in its brochure.

Some reports also referred to the publicising of IMCA services on notice boards, as well as other information about the MCA and Safeguards for relatives and users

Advocacy

Access to Independent Mental Capacity Advocacy (IMCA) services was described within some organisations and, as in CQC's 2010/11 report, several of these reports illustrated positive practice. In one example an IMCA was involved in supporting a decision about surgical treatment:

“*We looked at the records of a person with a condition that needed surgical treatment. An IMCA (independent mental capacity advocate) had met with the person, the doctor, a close relative and care workers responsible for supporting them. This had ensured that the person’s rights were considered and a decision made about whether the person should go ahead with the treatment and whether it was in their best interests.*”

There was evidence of referrals to the IMCA service. In one example, an attempt had been made to involve an IMCA to represent a patient lacking capacity and with no known next of kin. A best interests meeting had been held and the patient's social worker and psychiatrist had assisted in the process. Some reports also referred to the publicising of IMCA services on notice boards, as well as other information about the MCA and Safeguards for relatives and users.

There were a number of examples where organisations were actively working to engage people using services and their relatives in decision-making



Conversely, there were some instances of poor practice, including one organisation where there was no evidence that patients lacking capacity had been given access to advocacy or had a best interests meeting held on their behalf.

The explanatory notes to the Mental Health Act 2007 state that when a Safeguards authorisation is granted, care homes and hospitals must inform the person and their representative of the statutory right to an IMCA and how to obtain this support.¹¹ In the landmark case of *Steven Neary* the judge found that one aspect of Hillingdon Council's failure was that they did not promptly instruct a section 39D IMCA.¹²

The IMCA role was the first part of the MCA to be brought into practice, in April 2007. Research has demonstrated that it is a useful mechanism for protecting the human rights of people lacking capacity when decisions are being made concerning them by health and social care professionals.¹³ It is concerning that it seems still far from universally understood in health and social care.

Information and engagement

There were a number of examples where organisations were actively working to engage people using services and their relatives in decision-making. In some cases, access to independent advocacy and external agencies was being provided to individuals lacking capacity, and relatives were being involved in making best interests decisions involving possible restrictions to liberty:

“We noted that relatives or friends had been involved in making best interest decisions on their behalf about having constraints imposed on their liberty in accordance with procedures under the Mental Capacity Act 2005.”

Another example showed a service where staff were actively listening to patient concerns regarding the Safeguards and the MCA in a range of ways, including through one-to-one meetings with a named nurse, meetings with independent advocates, service users' questionnaires and through participation in a workshop.

One care home was described as having care planning documentation that included an 'involvement sheet' for all residents and relatives, which was used to record discussions; this included involvement and best interests discussions for residents unable to make their own decisions.

However, in one example a MHA Commissioner had walked around the ward and not seen any information for patients and relatives on advocacy, the MCA and the Safeguards. They had later found some resources in an office that could usefully have been made available.

¹¹ Mental Health Act 2007 Explanatory Notes s50 mental Capacity Act 2005:deprivation of liberty para 229 <http://www.legislation.gov.uk/ukpga/2007/12/notes/division/6/2/2/2>

¹² *LB Hillingdon v Steven Neary* (2011) EWHC 1377 (COP)

¹³ Commissioned by the Social Care Institute for Excellence and undertaken by the Norah Fry Research Centre at the University of Bristol. <http://www.scie.org.uk/publications/imca/files/IMCAreportFINALv35.pdf>

The importance of providing information to people using services and their relatives was referenced on several occasions, including provision of leaflets explaining the Mental Capacity Act in plain English, and support from staff in accessing IMCA services.

There were some descriptions of organisations working to disseminate information to people using services, to support involving them in decisions about their care.

“ *We were told that a patient information pack had been produced as a result of a patient survey and these included information on the Mental Capacity Act, how to access their own health records and clinical notes, and information about the complaints process and other information leaflets. The hospital told us that these had been distributed to all patients in the hospital.”*

In this reporting year CQC piloted the use of a questionnaire methodology to gain better understanding of the experience of people who have been the subject of applications for authorisation of the Safeguards. This provided useful learning on which to build future methodology but was not successful as an exercise in gaining reliable or direct evidence of the experience of people who use services. Further information on this process is in chapter 5 of this report.

03

CQC's findings on patterns of reporting of the Safeguards

Hospitals and care homes are required to notify CQC of an application to deprive someone of their liberty.¹⁴ In our last report we published a thematic review comparing notifications of Safeguards applications received by CQC with Health and Social Care Information Centre data from supervisory bodies on applications. The thematic review found that there had been noticeably more applications received by supervisory bodies than notifications received by CQC.



¹⁴ Care Quality Commission (Registration) regulations 2009 Regulation 18

Key points

- Providers should notify CQC without delay the outcome of any application to use the Safeguards.



- There has been an increase in reporting to both CQC (by care homes and hospitals) and to the NHS Information Centre (data provided by supervisory bodies) when compared with the period covered by the previous review.
- Reporting to CQC has increased at a higher rate than data reported to the Information Centre, indicating that reporting to CQC has improved.
- Reporting by hospitals is generally better than reporting by care homes. Additionally, the rate of reporting to CQC by hospitals has increased more than the rate of reporting by care homes.
- There is still substantial under reporting to CQC when compared with the number of supervisory body received applications that are recorded by the Information Centre. This matters because CQC monitors individual hospitals and care homes, and needs to be aware of MCA compliance, including appropriate and proportionate use of restraint, in these settings. It is important that CQC is told independently for many reasons, including enabling us to react in our role as monitor to individual instances, to assess compliance with relevant regulations and to spot trends in individual establishments or areas.

We repeated our thematic review in 2011/12. The results presented here cover the 12-month period from April 2011 to March 2012. The analysis is based on four quarterly extracts (Q1-Q4 2011/12) from the Information Centre (IC data) for supervisory body applications, and a single extract from CQC's data systems containing the notifications received by CQC over the same period (CQC data).

During the reporting period, the Health and Social Care Act 2008 regulations required care homes and hospitals to notify CQC of both an application for a Safeguards authorisation and the outcome. In June 2012, Regulation 18 was changed so now only the outcome of the application must be notified to CQC.

Supervisory body received applications

There were 11,399 applications received by supervisory bodies and notified to the Information Centre, equating to a rate of 28 per 100,000 population across the whole of England.

From these, 8,213 applications were made to local authorities (by care homes), while 3,186 applications were made by hospitals to primary care trusts (PCTs) (figure 4).

Notifications to CQC

There were 4,161 notifications received by CQC over the same period (figure 4). This equates to a much lower rate of 8 per 100,000 population across the whole of England.

From these, 2,909 notifications were of applications made to local authorities (by care homes), while 1,252 were of applications were made by hospitals to the appropriate PCT.



Comparison of reporting rates over the four quarters

To see whether there has been any increase in reporting we need to take the ratio of CQC received applications to supervisory body received applications, and then compare the two periods.

We can establish that in the first period the ratio of CQC received notifications to supervisory body received applications was 0.32. Another way to describe this would be to say that CQC received 32% of the applications that were received by supervisory bodies. Over the following three quarters (Q2, Q3, Q4 11/12) this rose to 37%, or a ratio of 0.37. These figures indicate a slight increase in reporting, although there is still a substantial lack of reporting to CQC.

Differences between sectors (CQC data and Information Centre data)

The data from the Information Centre does not separate out applications by sector. The supervisory body for a care home is a local authority (following rules for ordinary residence, so often but not always the authority where the care home is situated). The supervisory body for an NHS trust is their PCT (determined by which PCT commissioned the care, so again, often but not always the PCT where that trust is situated) and

Table 1 – Applications made by care homes

Period	Total number of Safeguards notifications received by CQC	Total number of Safeguards applications received by supervisory bodies	Ratio of supervisory body received applications notified to CQC	Population	Rate of Safeguards applications (CQC)	Rate of Safeguards applications (IC)
Q3 10/11 to Q1 11/12	1,600	5,233	0.31	51,809,700	3.09	10.10
Q2 11/12 to Q4 11/12	2,293	6,355	0.36	51,809,600	4.42	12.27

the supervisory body for an independent hospital is the PCT covering the hospital site. Examining numbers of applications received by PCTs and local authorities respectively can allow us to establish any difference in reporting rates between the hospital and care home sectors, and any sector specific changes since the previous review.

We can see that there has been an increase in overall applications from care homes as reflected in the IC returns (from 5,233 to 6,355 applications received by local authorities and reported by them to the IC). CQC received notifications for the corresponding period have risen from 1,600 to 2,292 (table 1). The ratio of reporting to CQC is slightly improved, up to 36% of the number reported to the IC, compared with 31% in the previous review. Despite this small improvement there is still a substantial amount of under reporting occurring to CQC from care homes.

Table 2 – Applications made by hospitals

Region (Hospitals/ PCT)	Total number of Safeguards notifications received by CQC	Total number of Safeguards applications received by supervisory bodies	Ratio of supervisory body received applications notified to CQC	Population	Rate of Safeguards applications (CQC)	Rate of Safeguards applications (IC)
Q3 10/11 to Q1 11/12	697	1,932	0.36	51,809,700	1.35	3.73
Q2 11/12 to Q4 11/12	1,087	2,455	0.44	51,809,600	2.10	4.74

There has been an increase in notifications received by CQC from hospitals, from 697 to 1,087, but also an increase in applications received by supervisory bodies (from 1,932 to 2,455) (table 2). There has been an improvement in reporting with just under half of applications now notified to CQC, compared with just over a third in the previous period. This is a larger improvement in reporting when compared with care homes, but there is still substantial under reporting to CQC.

The ratio of reporting to CQC is slightly improved, up to 36% of the number reported to the IC

Authorisation applications from hospital settings

Rates of usage of the Safeguards remain noticeably lower in hospitals than in care homes. There are some good reasons why this may be the case. Patients' mental capacity to consent to arrangements for their care and treatment may be rapidly improved, for example by treating an infection that has caused a person to be confused. While the Safeguards cannot be used to authorise treatment, it is clear from the Court of Protection Practice Direction 9E that they also cannot be used for serious medical treatment necessitating force to restrain the patient: such cases must be referred to the Court of Protection for authorisation.

If a person receiving treatment for a mental disorder refuses consent for that treatment, and the treatment can only be given in a hospital, the expectation is that the person's rights are more appropriately protected through consideration of detention under the MHA. However, it is clear from CQC's Mental Health Act Commissioner reports that some voluntary

The low numbers of hospital applications is however of concern when considered alongside the wider issue of MCA compliance in hospitals. CQC's findings suggest that in many hospital settings there is widespread lack of understanding of, or compliance with, the MCA

patients in mental health hospital settings, who lack capacity to consent to being in the hospital, are subject to de facto detention. For many of them, the appropriate route to protect their rights would probably be the MHA, but there are situations where a person who lacks capacity to consent is detained in the hospital for treatment of a physical disorder (and any treatment for mental health issues is only given with the patient's consent). Typically, the person's MHA detention has ended as no longer required, and the person effectively remains in a mental health ward while a suitable placement is identified. If this person is not free to leave, the Safeguards would be the appropriate route to protect the person's rights.

The low numbers of hospital applications is, however, of concern when considered alongside the wider issue of MCA compliance in hospitals. CQC's findings suggest that in many hospital settings there is widespread lack of understanding of, or compliance with, the MCA. Relatives are signing consent forms on behalf of people thought (often in the absence of evidence of appropriate assessment) to lack capacity to consent to treatment. Support workers report anecdotally that they too have been asked to sign consent forms when supporting a person to attend hospital. There is often little evidence of a process for identifying the decision that the person needs to make, assessing their capacity and recording the assessment (including efforts made to improve the person's capacity), and then carrying out a best interests process, including consultation with relatives or friends.



CQC's evidence suggests, for example, that hospitals and care homes where the MCA is poorly understood struggle to understand when they should request authorisation of a situation they deem to amount to a deprivation of a person's liberty

If the proposed treatment falls into the category of serious medical treatment, and the person lacks capacity to consent to or refuse the treatment, and has no family or friends to be consulted as part of best interests decision-making, the hospital must commission the Independent Mental Capacity Advocacy (IMCA) service. Stakeholders tell CQC that sometimes serious medical treatment is given to a person who has no identified family or friends, without the mandatory IMCA involvement.

The relationship between authorisation rates, CQC notifications and good practice

While some hospitals and care homes, and indeed some PCT and local authority supervisory bodies, make out a case that low levels of authorisation requests is a reflection of excellent practice, the real reason for the variation in rates is likely to be more complex. CQC's evidence suggests, for example, that hospitals and care homes where the MCA is poorly understood struggle to understand when they should request authorisation of a situation they deem to amount to a deprivation of liberty. Reports quoted above suggest they sometimes struggle even to recognise restraint as a matter needing careful scrutiny. Local authorities and PCTs vary in the amount of ongoing training and advice about the MCA, including the Safeguards, they offer to providers of health and social care.

We have not looked at the relationship between better reporting levels to CQC and better overall practice. Is accurate and timely compliance with reporting requirements an indicator of a wider approach to provision of health or social care that values lawfulness and understands the importance of transparency? This is something to explore in future, while seeking ways to encourage all managing authorities to notify CQC of activity under the Safeguards.

Notifications are a key source of information for CQC's monitoring responsibilities. Notifying outcomes of applications is a statutory requirement; failure to do so is an offence. CQC has taken steps to improve the awareness of its staff in relation to this requirement, and providers who fail to notify risk enforcement action. In June 2012 regulations came into force that state that providers must use the notification forms prepared by CQC to inform us of important events including outcomes of Safeguards requests. It will be interesting to see if this improves the reporting of requests.

04

Monitoring of supervisory body operation: regulatory compliance among supervisory bodies

To request authorisation of an unavoidable deprivation of liberty under the Safeguards, a “managing authority (in NHS hospitals, it is the trust responsible for their administration, in independent hospitals and care homes it is the person or organisation registered to carry on relevant “regulated activities”) must apply to the appropriate “supervisory body”.



Key points



- There is a high level of variation across the 13 supervisory bodies sampled in the way they discharge their responsibilities.
- Within the sample of 13 supervisory bodies there is a range of training/briefing given to authorisers, from none (three respondents), to a maximum of half a day's training (nine). Eight supervisory bodies reported arrangements for ongoing regular briefings or one-to-one support opportunities.
- The numbers of applications for a standard authorisation received, and the number approved, varied greatly across the supervisory bodies that were surveyed. The average percentage of applications approved was 64%, covering a range from 0 to almost 80%.
- Ten supervisory bodies offered some kind of planned, continuous support to managing authorities in relation to the MCA in general and the Safeguards in particular.

If the person is in a care home the supervisory body will be a local authority, and if the person is in hospital, it will be a primary care trust (until 1 April 2013, when under the Health and Social Care Act 2012 primary care trust supervisory body powers will transfer to local authorities).

In making its decision, the supervisory body commissions six assessments from a minimum of two assessors who have received specific training for their roles under the Safeguards. These include a best interests assessment. This assessment considers whether the arrangements proposed for the person's care or treatment amount to a deprivation of liberty as defined in case law, and, if so, whether this is in the person's best interests, proportionate, and the least restrictive option that can be identified to keep the person safe.

If all the assessments support authorisation, the supervisory body must give an authorisation under the Safeguards. The authorisation is given for a specific period of time, which cannot exceed one year. It may contain conditions intended to reduce the need for a deprivation of liberty.

The supervisory body must also appoint a relevant person's representative, who is usually a family member. It must also consider whether the relevant person or the representative would benefit from support from an Independent Mental Capacity Advocate (IMCA), both to understand the nature of the authorisation and, most importantly, to challenge it should they so wish. Local challenge can be made to the supervisory body by asking for a review of any of the assessments: if this does not answer the concerns of the person, representative or IMCA, they have a right to challenge the authorisation in the Court of Protection.

The core duties and responsibilities of the supervisory body are to:¹⁵

- Respond to requests for standard authorisation.
- Respond to requests for an extension of an urgent authorisation.
- Commission the relevant IMCA service when required to do so.
- Commission the six assessments required for a standard authorisation.
- Grant the standard authorisation of deprivation of liberty when all assessments are positive, or
- Not grant the standard authorisation of deprivation of liberty when one or more assessment is not met.
- Appoint the relevant person's representative.
- Respond to requests to review a standard authorisation of deprivation of liberty and carry out a review when appropriate.
- Suspend and where appropriate lift a standard authorisation if the person is detained under the Mental Health Act 1983 for up to 28 days.¹⁶
- Terminate the deprivation of liberty standard authorisation when appropriate.
- Terminate the appointment of a relevant person's representative when appropriate.
- Respond to requests to investigate alleged unauthorised deprivations of liberty.

If a person has no relatives or friends willing to be involved in the assessment process, the supervisory body must appoint an Independent Mental Capacity Advocate (IMCA) to represent the person and report to the supervisory body

The supervisory body has the right to set conditions with the intention of lessening the need to deprive the person of their liberty. In addition, the 'relevant person', the phrase used in the Safeguards to describe the person deprived of liberty, has a right to challenge the authorisation, and a representative (relevant person's representative) is appointed who also has the right to challenge the authorisation. If a person has no relatives or friends willing to be involved in the assessment process, the supervisory body must appoint an IMCA to represent the person and report to the supervisory body. If an authorisation is granted for a person with no known family or friends apart from their paid staff, the supervisory body must appoint a paid representative. These are often people employed by an advocacy service.

IMCA services are independent of local authority control in their operational work. However the local authority through its supervisory body role appoints the IMCA, and through its contract department holds the funding resource for the IMCA service

If a deprivation of liberty is identified and authorised, it is subject to a fixed duration (a maximum period of one year). Many supervisory bodies only rarely authorise for anything like that long, averaging about three months.

¹⁵ Mental Capacity Act 2005 Schedule A1

¹⁶ Schedule A1 to the Mental Capacity Act 2005 para 93 (2) does not specify who holds the responsibility to suspend the standard authorisation. The standard forms 14 and 15 issued for the suspension of the standard authorisation and the lifting of the suspension are listed as forms for the managing authority to complete. This guidance follows para 8.30 of Deprivation of Liberty Safeguards Code of Practice which specifies that the standard authorisation is suspended, and the suspension lifted, by the supervisory body.

Pilot study of structured interviews with supervisory bodies

In our 2010/11 report on monitoring of the Safeguards, we identified a priority to improve access to information on supervisory bodies. We have developed our thinking on this in consultation with external stakeholders. Supervisory bodies hold both 'quasi-judicial' and key assurance roles in the Deprivation of Liberty Safeguards system. As such, it seems inarguable that some focus on their activities should fall within the scope of CQC's duty to monitor the operation of the Safeguards. High levels of variation in the activities of supervisory bodies have been apparent from the NHS Information Centre's data on authorisations. CQC's intention is to explore areas of supervisory body functioning other than those in the Information Centre data, with the objective of better understanding the reasons for such variation.

CQC designed a semi-structured interview, in consultation with expert stakeholders, to pilot with a sample of supervisory bodies. We held 13 interviews with supervisory bodies, selected randomly across England. Twelve of the supervisory bodies were jointly managed for both the local authority and PCT functions, and one was a local authority working alone. Hence there was no exploration of the workings of a PCT stand-alone supervisory body.

This pilot study, though small, produced some useful pointers to matters to look at in the future. It also highlighted areas where the questions were perhaps not sufficiently precise to gain unambiguous answers, and suggested other areas that could profitably be explored with supervisory bodies. The findings are summarised below under headings relating to the specific responsibilities on which CQC requested information.

The number of people signing authorisations varied from two to eight, roughly in proportion with the size of authority and its geographical area

Authorisers

The number of people signing authorisations varied from two to eight, roughly in proportion with the size of authority and its geographical area, with an average of five. A question that was not addressed in this pilot study, but could profitably be explored, relates to the seniority of authorisers, and the extent of their separation from the day-to-day management of the supervisory body. It is clear from the Neary case that they are responsible decision-makers within the process of authorisation, rather than mere formal signatories.¹⁷

In light of this, it is interesting that within this small sample there is a great range of training/briefing given to authorisers, from none (three respondents, about a fifth of the total), to a maximum of half a day's training (nine, or two-thirds of the total). Eight supervisory bodies, or three-fifths of the total, reported arrangements for ongoing regular briefings or one-to-one support opportunities.

¹⁷ The London Borough of Hillingdon -v- Steven Neary and Mark Neary and the Equality and Human Rights Commission [2011] - see appendix A

Relationships with safeguarding teams

Ten of the 13 supervisory bodies were co-located with adult safeguarding teams and shared staff over both functions. The remaining three had separate teams but shared a manager. On the face of it, the case for a link between the management of safeguarding and the Safeguards is attractive, but there are some risks. For smaller authorities in particular, the question is raised about how to maintain the conceptual distance between their safeguarding and their MCA (including the Safeguards) functions.

The approach taken by safeguarding teams tends to focus on protection from abuse, whether a person has capacity or not, whereas the Safeguards are a measure specifically located within human rights law to protect the human rights of people lacking capacity. While human rights should be and often is an important dimension to safeguarding and protection, some court cases have shown that professionals can focus on protection to the detriment of autonomy and rights, and fail sometimes to work within the best interests framework of the MCA.

Application numbers and pressures on decision makers

The numbers of applications for a standard authorisation received, and the number approved, varied greatly across the supervisory bodies that were surveyed. For example, the number of applications for standard authorisation that were not accompanied by an urgent authorisation varied from 1 to 118, and the average percentage approved, 64%, covered a range from 0 to almost 80%. Numbers of those accompanied by an urgent authorisation ranged from 14 to 113: the average 'approved' was just under a half, but ranged from 27% to nearly 70% (one supervisory body was unable to provide data in relation to approved applications: potentially a worrying finding but at this stage without any understanding of the reason).

The proportion of standard authorisation requests, not accompanied by an urgent authorisation, completed as they should be within 21 days, varied from 80 to 100%, averaging 98%.

Just over two-thirds of all authorisation requests were accompanied by an urgent authorisation, giving the supervisory body seven days to complete all assessments and grant or not grant the authorisation.

The proportion of these actually completed within seven days, as required in other than exceptional circumstances, was significantly lower at about 79%, with a range from 0 to 98%.

Where data were provided about extensions to the time allowed for decisions about applications accompanied by an urgent authorisation (68 cases), the majority were of seven additional days (the maximum allowed) with a range among the others from one to six additional days. Where information was provided about the cause of delays in resolving these applications, a number of factors were reported. The most common was problems caused by annual leave, bank holidays and weekends (seven). The next most common was difficulty in arranging interviews with significant people at short notice, typically family members but also other professionals (six).

The numbers of applications for a standard authorisation received, and the number approved, varied greatly across the supervisory bodies that were surveyed

Other problems reported by supervisory bodies were:

- Delays in finding best interest assessors or mental health assessors (three).
- The need to avoid rushed decision-making (three).
- Delays in finding IMCAs (two).
- Delays in requested information being provided by other local authorities/PCTs (three in each case).
- Confusion over whether the Mental Health Act was the more appropriate mechanism to protect the person's rights (one).

Five supervisory bodies said the short time frame was a general barrier to good practice, particularly in relation to problems caused by weekends, bank holidays, annual leave and interviewee availability.

Different authorities have adopted different ways to manage this.

One authority sampled said that, rather than breach timescale requirements when facing a challenging application accompanied by an urgent authorisation, they sometimes authorised a very short period of deprivation of liberty, during which time they undertook a more thorough and considered assessment process.

This seems a good response to the issue. The regulations state that an application accompanied by an urgent authorisation should be dealt with in seven days unless there are "exceptional reasons". Examples of such exceptional reasons given in the Safeguards Code of Practice are:

- "It was not possible to contact a person whom the best interests assessor needed to contact.
- The assessment could not be relied on without their input.
- Extension for the specified period would enable them to be contacted.

"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".¹⁸

When an authorisation request accompanied by an urgent authorisation cannot be dealt with during the required time frame, the managing authority must ask the supervisory body to extend the urgent authorisation for a maximum of a further seven days. The thinking here is that an urgent authorisation, given by a care home or hospital to itself, represents a 'lay opinion' being used potentially to deprive a person of their liberty. For this reason, the time this is allowed to continue without being assessed by those with specific expertise should be no longer than necessary. CQC intends to explore in more detail next year the reasons given by supervisory bodies for extending urgent authorisations.

Four out of the 13 supervisory bodies sampled commented that managing authorities sometimes did not seem to understand the principles of the MCA or their role in Safeguards applications, or provided poor quality information in applications.

4 of 13

supervisory bodies sampled commented that managing authorities sometimes did not seem to understand the principles of the MCA, their role in Safeguards applications, or provided poor quality information in applications

¹⁸ Deprivation of Liberty Safeguards Code of Practice paras 6.23; 6.24

Three of those sampled said that receiving multiple applications at the same time could stretch available resources and lead to delays. A different group of three supervisory bodies said that lack of access to section 12 approved medical assessors (who can carry out the eligibility assessment as well as the mental health one) has caused problems.

Where staff shortage, for example a lack of available assessors, is the reason for extending an urgent authorisation, this should be addressed by the relevant supervisory body through its governance mechanisms.

Other barriers to good practice quoted by one or two supervisory bodies were:

- Recent court decisions about the scope of restriction as opposed to deprivation of liberty.
- The complexity of application forms.
- Lack of understanding among colleagues of the human rights agenda as opposed to adult safeguarding.
- Lack of resources in general.
- Lack of resources to monitor practice in managing authorities.
- Lack of best interest assessors.
- Lack of a robust quality assurance process around applications.
- Instability in the health care system caused by NHS reforms.
- Professional indemnity insurance (for self-employed assessors).
- Lack of understanding of the Safeguards process in NHS trusts.
- Problems flowing from poor quality care management or lack of access to a current care manager.
- Reluctance of some community care teams to release staff for best interest assessor duties.
- Lack of Independent Mental Capacity Advocates.
- The cost of Court of Protection hearings.

Where staff shortage, for example a lack of available assessors, is the reason for extending an urgent authorisation, this should be addressed by the relevant supervisory body through its governance mechanisms



Ten supervisory bodies offered some kind of planned, continuous support to managing authorities in relation to the MCA in general and the Safeguards in particular

Assessor recruitment and retention

Twelve of the 13 supervisory bodies directly employed some or all of their best interest assessors. Of these, eight also used self-employed contractors some or all of the time (often when facing challenging timescales or a rush of concurrent applications). One of the supervisory bodies only used self-employed best interest assessors. None contracted with a best interest assessor supplier agency.

Eight of the supervisory bodies actively monitored the regulatory requirements for best interest assessors and undertook a continuous process of recruitment and related training.

The interview methodology was less successful in gathering information about mental health assessors. Four supervisory bodies said that their local health trusts supplied these, and two referred to a regional pool to cover busy periods. One referred to engaging with mental health assessors to provide ongoing support and training.

Support to assessors

Ten of the supervisory bodies have an annual continuing professional development (CPD) hours/training requirement in relation to assessors. Within the current pilot study, it is impossible to relate this finding to the mandatory annual refresher training required for all assessors under the Safeguards. Eight of the supervisory bodies provide relevant training and development opportunities themselves, of which four include legal briefings.

Three have a regular reapplication process. Three require attendance at one-to-one meetings (supervision); one undertakes annual appraisals of the assessor's best interest assessor or mental health assessor practice; three require attendance at regional meetings. One requires that assessors must have completed at least one assessment each year to remain current. One requires an annual DBS check (formerly known as Criminal Records Bureau check). There is wide variation in requirements in relation to assessor CPD. About half of the supervisory bodies showed a relatively structured approach to requiring and checking on assessor CPD; three made very few demands and checks. CQC plans to explore this further.

Support to managing authorities

Ten supervisory bodies offered some kind of planned, continuous support to managing authorities in relation to the MCA in general and the Safeguards in particular. Of these, seven offered telephone support throughout the working day. Two offered an e-learning course; two others gave individual feedback to applicants after each request for authorisation; four analysed applications and gave specific remedial training to applicants where needed.

They offered a variety of support mechanisms to managing authorities. One supervisory body stood out as working in a number of ways to help the managing authority understand their role and meet requirements relating to it, including making sure that they understood any conditions. Among the cohort, one referred to reviewing relevant data at board level, and regularly discussed Safeguards activity and requirements with all managing authorities; one went out of its way to visit those that had not

Eight supervisory bodies would consider accepting an assessment that was up to a year old on a case-by-case basis, in line with the basic Code of Practice

submitted any applications; three published regular newsletters; two had relevant pages on their website, including relevant forms for download, and two provided training on request.

There were single examples of where supervisory bodies' support was just responding to requests for information, hosting occasional meetings or offering no information at all about their perceived or actual role with managing authorities.

Equivalent assessments

Eight supervisory bodies would consider accepting an assessment that was up to a year old on a case-by-case basis, in line with the basic Code of Practice requirements in relation to the validity of equivalent assessments.

One of these eight normally accepts assessments if they are less than six months old; one only accepts assessments if they are less than six months old, and one only accepts mental health assessments if they are less than three months old. Four said that they would always commission fresh assessments if there had been a change of circumstances since the last assessment; three said that they commissioned fresh assessments for each application.

The structured interview question did not differentiate among assessments, but supervisory bodies must remember that a capacity assessment, in particular, relates to situation and time specific capacity, so there are likely to be real problems with the use of increasingly out of date assessments.

Peer group support

Ten of the 13 supervisory bodies said that they were engaged with regular and continuing peer group support structures, mostly (seven) as active participants in their regional MCA/Safeguards network. One reported informal contacts with neighbouring authorities, and two reported no peer support contacts at all.



Supervisory bodies must allow the assessors to exercise professional independent judgement

Scrutiny of best interest assessor recommendations

Eleven supervisory bodies said they had developed pre-authorisation quality check arrangements in relation to best interest assessor recommendations, typically through specialist staff checks by members of the Safeguards team. Two described no review process, except that provided presumably by the authoriser.

Three of the supervisory bodies described well developed support and scrutiny structures, with features such as quality assurance and control arrangements, clear expectations about requirements, and support for managing authorities as well as assessors and authoriser. They also referred to management information gathering and analysis, and other features of a closely managed process.

The rest relied on their Safeguards team's scrutiny of applications to assure and evaluate quality. In this small study, this difference did not appear to be associated with the size and type of supervisory body.

Supervisory bodies must allow the assessors to exercise professional independent judgement. Within this pilot study, it is unclear what reports of changing a best interest assessor's recommendations refer to. This could be an authoriser over-ruling the assessor, or asking for further evidence to support their assessments, or the right of the authoriser to add conditions to the authorisation and to shorten (but not lengthen) the period of authorisation from that recommended by the best interest assessor. Within that caveat, eight supervisory bodies reported having never changed a best interest assessor's recommendations in relation to authorisation and conditions. One changed a recommendation once, one twice, and one changed recommendations six times. There was no information from one supervisory body.

Involving relevant person's representatives

There was a range of understanding of this question within supervisory bodies, but some picture of practice differences does appear. Ten of the supervisory bodies report that best interest assessors involve relevant person's representatives in the process. Three supervisory bodies also referred to Independent Mental Capacity Advocate contact with relevant person's representatives. Two said that their Safeguards lead routinely made contact with representatives, and one that they also sent representatives written information about the process.

Ordinary residence

Just over half (eight) of the supervisory bodies had not experienced problems over a relevant person's ordinary residence, but six had. Two referred to residence requirements not being understood by the managing authority, two to difficulties in establishing a person's ordinary residence, and one suffered from a lack of clarity on the forms. Four referred to funding-related issues such as out-of-authority placements by other commissioners and self-funding residents. One referred to confusion caused by issues related to continuing health care funding.

It is worth noting that, when PCT responsibilities for the Safeguards transfers to local authorities, hospitals too must identify the relevant supervisory body based on the patient's ordinary residence. Local authority supervisory bodies must be prepared to untangle more ordinary residence conundrums.

Independent Mental Capacity Advocates (IMCAs), relevant person's representatives (RPRs) and review processes

Just over half (eight) of the supervisory bodies had not experienced problems over a relevant person's ordinary residence, but six had

It is good practice, following guidance from the Department of Health, for a supervisory body to make available an IMCA to every unpaid relevant person's representative. Often an initial appointment offer is made at the time the authorisation is granted, so that the Advocate can explain in more detail what the authorisation entails, and discuss fully with the representative how to request a review of any of the assessments or how to challenge the authorisation in the Court of Protection. It is currently difficult to assess how many representatives are offered an Advocate appointment, how many take it up, and whether this help makes it more or less likely that the authorisation will be challenged, either through a request for a review of any of the assessments, or to the Court of Protection:

The fifth annual report on the Independent Mental Capacity Advocacy Service 2011/12 quotes the recommendation from the Association of Directors of Adult Social Services/Social Care Institute for Excellence good practice guide covering this area for:

“ *Supervisory bodies to instruct 39D IMCAs at the start of all standard authorisations where a person has a family member or friend appointed as their representative. This gives the person and their representative the opportunity to meet a 39D IMCA and so that they are in a better position to decide if they need the support of one at that point, or sometime in the future.”¹⁹*

The report shows an increase of 18% in the number of IMCA instructions associated with use of the Safeguards. In total there were nearly 2,000 Safeguards referrals to IMCA services in 2011/12.

Feedback from expert stakeholders about the findings and potential usefulness of the approach as a monitoring tool has been very positive

CQC's next steps with supervisory bodies

CQC has been encouraged by the process of designing and conducting this pilot study. The supervisory bodies that have been approached so far have been co-operative. Feedback from expert stakeholders about the findings and potential usefulness of the approach as a monitoring tool has been very positive.

Unlike CQC's relationship with managing authorities, where regulatory operations and information gathering are part of our core business, CQC's relationship with local authorities is much more open to negotiation. We intend to develop this approach in the coming year – but the success of this initiative as a monitoring tool will depend to a significant extent on the willingness of local authorities to collaborate with CQC. The shared objective must be ensuring that the Safeguards system operates to maximum effect for the protection of vulnerable adults in health and social care settings.

05

Understanding the experience of people who have been the subject of authorisation applications

In last year's report CQC said that it would do more to understand the experiences of people with direct experience of this provision in practice. In 2011/12 CQC piloted an approach to doing this.



This work was initiated through CQC's Involvement Teams' networks of national involvement contacts, with a call for people/organisations having direct experience of the Safeguards. A briefing for these contacts was prepared including information about the Safeguards, CQC's monitoring role and the purpose of this initiative. It very quickly became evident that identifying people with direct experience of the Safeguards, as opposed to some other form of deprivation of liberty, would be a challenge. Early on in the process CQC identified two or three people through its Experts by Experience programme who had recently had experience of the Safeguards, and who initially agreed to take part, but subsequently changed their minds.

Key points

- CQC piloted an approach to gathering information on the experience of people who have been the subject of authorisation applications.
- This provided useful learning on which to build future methodology but was not successful as an exercise in gaining reliable or direct evidence of the experience of people who use services in this context.
- CQC plans to carry out a new pilot study involving relevant person's representatives and Independent Mental Capacity Advocates, to increase efforts to understand people's personal experiences of the Safeguards in practice.

One of CQC's partners in this work is the University of Central Lancashire (UCLan) in Preston. UCLan holds the contract for SpeakOut, a national network of 95 community groups that carry out work for CQC such as commenting on policy changes, public leaflets, policy documents and inspection guides. More information on SpeakOut can be found at www.speakoutnetwork.org.

In the early stages of this work some of the SpeakOut groups thought they would be able to identify potential interviewees. In practice this proved difficult, so the University of Central Lancashire approached a specific supervisory body which was extremely helpful in supporting this initiative, inviting UCLan's representative to participate in their own training on the Safeguards, enabling her to make contacts and carry out some interviews on behalf of CQC.

In selecting the sample for interview, priority was given to relatives over care home staff. Some declined and asked that the care home manager be interviewed instead. Some people didn't have any relatives, carers or friends and the interview had to be done with the care home manager. People subject to the Safeguards were also invited to attend, but in practice this proved impossible because the people concerned were so unwell or lacked the capacity to understand the request to be involved. All of the interviewees were very co-operative.

Ten interviews were conducted focusing on the experiences of 10 individuals who were either subject to the Safeguards or had been subject to an application for authorisation of the Safeguards. None of these individuals were thought, by carers or their relatives/friends, to have sufficient capacity to be interviewed themselves: all 10 suffered significant dementia and none took part in the interviews. Staff from the care provider answered on behalf of the person in four cases; family members, and a friend, acted as respondent for the other six people. All 10 people had someone to speak up for them, though in one case this was minimal. Friends were the most active supporters in one case. Just three had continuing external professional involvement, such as a social worker.

All 10 were currently living in the care home that had submitted the application for authorisation under the Safeguards. Nine were older people, and one, aged 60, had a learning disability. They all suffered from significant dementia.

Seven out of the 10 applications had not been granted. The ratio of granted to not granted, while somewhat low, is broadly commensurate with national rates.

The feedback gives a flavour of variation that very much reflects the findings from the other elements of CQC's monitoring activity presented in this report.

The main points to emerge from the responses were as follows:

Most surveys showed continuing positive effort of some kind on the part of the care home to promote choice and inclusion

- Two interviews indicated a positive wish on the part of the person to be living elsewhere. Three had no wish to be elsewhere, and there was no information about the other five.
- Eight interviews reported a meeting where the person's placement was discussed: one person said that there had been no meeting that they were aware of, and there was no information about one.
- One respondent family indicated that they had been told about their right to appeal. None of the interview responses indicated knowledge of how long the authorisation was for.
- Most responses showed continuing positive effort of some kind on the part of the care home to promote choice and inclusion. Some, however, appeared to have concluded that the person's dementia meant that they were simply incapable of inclusion in any decision. This is worth exploring in more detail, but we note that significant areas of some interview forms, dealing with choice and privacy, were replied to with 'not applicable'. The creative ways in which three of the interviews described encouragement to the person to be involved were only partially reported by four others and hardly, if at all, by the remaining three.
- Privacy issues were little reported, and widely answered with 'not applicable'. This may suggest assumptions that people who lack capacity to take a number of decisions, due to their dementia, might be expected not to require the respect for privacy that most people take for granted.

None of the interview responses indicated knowledge of how long the authorisation was for

- None of the respondents reported ill-treatment or any person being ‘told off’ about their behaviour. Only one interview described restrictions on behaviours, which took place after a best interests process (the person liked to remove their clothing in communal areas). No other restrictions were reported, which is somewhat surprising given that all 10 had been the subject of application under the Safeguards.
- Relatives reported a sense of distance from important decision-making, for example in relation to such matters as choice of where to live, and the application under the Safeguards. It was striking that on balance they did not seem to find this surprising or unusual.
- Three were told about important decisions only after they had been taken; three made no comment; and four reported involvement in decisions about restrictions and the application under the Safeguards, but did not appear to have experienced comprehensive involvement. None of them complained about this. Only the friends responding on behalf of one person spoke up about this sort of decision, and about the importance of ensuring that the person they had known before the dementia was recognised.

This work provided useful learning on which to build future methodology. In particular, future work of this nature will need to give further consideration to:

- The design and implementation of a methodology for obtaining the experience of people who are frail and have cognitive impairments.
- How CQC works with stakeholders and strategic partners to identify samples of people with direct experience of the Safeguards processes.
- Developing an approach that can seek the views and experiences of families and Independent Mental Capacity Advocates on the operation of the Safeguards in practice. A more specifically targeted approach in a specified area might prove to be more fruitful.

CQC intends to build on this work in the coming year, recasting the pilot, and seeking ways to make sure that the voices of people at the heart of the Safeguards and of their representatives are heard in CQC’s monitoring work. CQC intends to give further consideration to the outcomes of this project, in discussion with people who use services, to develop ideas on how to help take this work forward.

06

Conclusions

There continues to be confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty. Recent court cases have ruled that there is no universal definition. Decisions can only be made on individual circumstances. The relationship between care, appropriate restrictions of liberty, the Deprivation of Liberty Safeguards and the wider Mental Capacity Act (MCA) has become complex and potentially confusing.



The Safeguards cannot be understood without reference to the guidance on good practice that is found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the MCA. This is also true for CQC both in its role as regulator and in monitoring the use of the Safeguards.

CQC expects the following:

- **Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Safeguards.** Training in the Act and the Safeguards is still patchy and not always reflected in improvements in practice. The use of care plans, recording of incidents, and gathering of feedback from staff, people who use services and their relatives all need to improve. Such practice needs to show that it complies with the principles of the MCA, and to demonstrate an understanding of when and how to explore a person's capacity to make a specific decision, and of best interests decision-making. Stronger links between managing authorities and local Independent Mental Capacity Advocate services may be one way of improving staff knowledge.
- **Care providers must implement policies that minimise the use of restraint.** Restraint should always be a 'last option'. Encouraging positive behaviours, with a view to minimising the use of restraint, can be explored in forums such as team meetings. CQC expects to find a greater understanding of the best interests and least restriction principles in the MCA and of the practice implications of the MCA's provisions on restraint. Staff need to be aware of when lawful restraint might be moving into a deprivation of liberty that requires specific authorisation.
- **Providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Safeguards.** CQC's inspectors saw examples of friends and relatives being excluded from best interests decision-making, contrary to the requirements of the law. Providers and commissioners must go to greater lengths to consult with relatives and friends as part of the process when using the Safeguards.

What CQC will do next

CQC recognises that ongoing improvements in its monitoring of the Safeguards, and the wider MCA, are vital tools to protect and promote the human rights of vulnerable people in health and social care.

In line with its proposed strategic direction over the next three years, CQC intends to strengthen how it meets its responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's unique sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated strong support for this.

CQC will:

- **Improve inspectors' understanding of the Mental Capacity Act and the Safeguards.** We will continue the roll-out of training and resources for our staff on mental capacity and the Safeguards. We will work with stakeholders to make sure our guidance for providers and for CQC staff is up to date and reflects relevant case law.
- **Develop its work with local authorities in their role as supervisory bodies.** We intend to develop this approach in the coming year. However, the success of this initiative as a monitoring tool will depend to a significant extent on the willingness of local authorities to collaborate with CQC. The shared objective must be ensuring that the Safeguards operate to maximum effect for the protection of vulnerable adults in health and social care settings.
- **Further develop ways to gather the experiences of people lacking capacity and their friends, families and carers.** We will carry out a new pilot study involving people's representatives and Independent Mental Capacity Advocates. This will help increase CQC's understanding of the experiences of people while they are subject to the Safeguards and help better understand the quality of service.
- **Continue to promote evidence of what works well.** We will highlight best practice and work to communicate this information to providers, staff and other stakeholders.

Appendix A:

Developments in case law

Decision-making by local authorities

In our last report, we included a summary of the case of *The London Borough of Hillingdon -v- Steven Neary and Mark Neary and the Equality and Human Rights Commission [2011] EWHC 1377 (COP)* from May 2011. This involved Steven and his father challenging through judicial review the decision of Hillingdon Council to refuse Steven's request to return home, and to issue a series of standard authorisations keeping him resident in a care home. The Court of Protection judge in the case, Mr Justice Peter Jackson, made a number of criticisms of Hillingdon's practice in issuing the authorisations, finding them to have been made unlawfully as a result of the local authority's failure to be clear about the capacity in which it was making its various decisions affecting Steven.

There has been some debate about the case, and about the criticisms it made of practice within supervisory bodies. These have recently been picked up by the DH in a Funding Fact Sheet (24 September 2012) distributed to local authorities and informing them of the funding that will be made available for them to exercise their Safeguards function in 2013/14. It reminds local authorities of the need to keep up with current case law, in particular the Neary case, so as to ensure that their Safeguards decision-making practices are sufficiently independent of other practice.

In another case taking place in 2011, *C -v- A local Authority & LM & LPM & the PCT [2011] EWHC 1539*, the High Court considered C's challenge through judicial review to certain care measures, and was very critical of decision-making within the local authority caring for him. The case did not involve the Safeguards, and so the local authority was not acting as a supervisory body. P was a young man with autism and severe learning disability living in a residential school who objected to his frequent confinement within a small room. Ryder J found that by giving no consideration to the Safeguards or the Codes of Practice relating to the 1983 Act or the 2005 Act, the level of multi-disciplinary decision-making that should be expected for people in residential settings was not present, and this was unacceptable.

In a subsequent challenge involving the same matter, *WPC -v- CP, LM, LPM, ALWPCT and an Organisation [2012] EWHC 1944 (COP)* C's brother (LPM) made an application against the local authority for his costs in the earlier case, which the court granted. In doing so, the Court of Protection made further criticism of the local authority decision-making, saying that by not considering the implications of C having been deprived of his liberty, its actions were tainted by illegality. It went so far as to describe the decision-making as "impoverished and disorganised".

Meaning of deprivation of liberty

We also included in last year's report a summary of two very significant cases setting out the factors to be taken into account when deciding whether there has been a deprivation of liberty. These were *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, both of which indicated that in order to ascertain whether the necessary objective element of a deprivation exists, it is necessary to look at the "relative normality" of a person's situation. The Supreme Court has given its permission for an appeal in relation to both cases. It is currently expected that the appeals will be heard together, but probably not until much later in 2013. This means there is continuing uncertainty about the meaning of a "deprivation of liberty" for MCA purposes.

The "relative normality" approach to determining a deprivation of liberty, in which the person in question must be compared to someone of similar capabilities, has been criticised in many quarters, not least by the Court of Protection itself. In the case of *A Local authority -v- PB and anor* [2011] EWHC 2675 Charles J said at para 63 - the Cheshire case "causes as many problems as it solves." Similarly, Baker J pointed out in the recent case of *CC -v- KK and STCC* [2012] EWHC 2136 (COP) that the "relative normality" test set out in the Cheshire West case was the aspect of the case most likely to receive scrutiny by the Supreme Court, pointing out that it is potentially discriminatory. He also expressed the view that the appeals will consider the relevance of the reason for a person being required to remain in a particular place, and that the Supreme Court will have to take into account the recent decision in *Austin and Others -v- UK* Applications 39692/09, 40713/09 and 41008/09, [2012] ECHR 459, made by the European Court of Human Rights. This case involved the police, and their practice of "kettling", rather than the Mental Capacity Act, but as the court considered in detail the implications of the reasons for any restrictions on a person's movements in finding a deprivation of liberty, it has clear parallels with the Safeguards.

The *KK* case itself involved an 82-year old woman who was living for most of the time in a care home, but who was also enjoying supervised visits to her own home. The court was required to make an assessment of *KK*'s capacity, which was a finely balanced judgement in her case, and also to determine whether *KK*'s care regime was depriving her of her liberty. She had, throughout the time she had lived in the care home, expressed her desire to return home, and a series of standard Safeguards authorisations had been made following an initial, urgent authorisation given by the provider of the care home itself.

Having acknowledged the problems presented by the uncertainty in the law pending the appeals to the Supreme Court, Baker J focussed on KK's "concrete situation". She was disabled to the degree that she was completely dependent on others for her care and treatment, and so by comparing her situation to anyone similar, the court found that KK's life was physically, significantly restricted. Also of significance was the fact that KK's needs had to be accommodated alongside other residents, meaning she had to wait to receive the attention she wanted, and the fact that when she did go home, she often expressed the wish to stay - but she couldn't, due to a lack of staff. However, the court found other factors "pointing away from a finding of deprivation of liberty", including the fact that restraint and sedation were never used, and that KK's door was never locked. KK was always consulted about what she wanted to do and how her care should be arranged, and there were no restrictions at all on her contact with other people. The fact that she was being assisted and enabled to live some of her life at home was also very significant. The court found that the care KK was receiving did not deprive her of her liberty as she had not lost a significant level of personal autonomy. KK's disability itself imposed a degree of restriction on her life, and the circumstances of her placement did not significantly add to that.

The right to a private and family life during a deprivation of liberty

The case of *J Council -v- GU and Others* [2012] EWHC 3531 was considered by the Court of Protection in December 2012, when the local authority responsible for GU's care applied for certain declarations about his care and treatment. It involved a man, G, who lacked capacity, and required medical treatment for his mental disorders, which included paedophilia. He was placed in a privately run care home, regulated by CQC, and the local authority, the health authority treating G, the care home provider and CQC as the regulator became involved as interested parties while G himself was represented by the Official solicitor.

G's behaviour was deemed potentially dangerous to the public, and as a result rigorous restrictions were placed on him, which he accepted. These included monitoring his correspondence and telephone contact, as well as subjecting him to spot searches. The Court of Protection had no difficulty in finding that the regime amounted to a deprivation of his liberty, or that the deprivation was justified - an order was therefore made requiring G to live at the care home in question, with the agreement of all parties. However, the judge found that making the order under the Mental Capacity Act 2005 raised questions about his right to enjoy a private and family life under Article 8 of the Convention on Human Rights.

Mostyn J found that although interference with a person's Article 8 rights is permissible when the interference is "compatible with the rule of law", there was a lack of proper legal basis for the interference G was being subjected to. Despite the deprivation of G's liberty having been made in accordance with the law, the judge was concerned that the further interference the monitoring regime he was subject to represented was not legally mandated. He pointed out that had G been detained in accordance with the Mental Health Act 1983, interference with his correspondence and telephone calls would have been carried out in accordance with secondary legislation. There are no equivalent procedures included in the Mental Capacity Act 2005.

The judge, and the Official Solicitor, were satisfied that in G's case, the interference with his private life had been expressed in detailed written policies that had been approved, and contributed to, by all parties to the case, and had then received the Court's endorsement. However, the judgement raises questions about whether the law offers adequate protection of the Article 8 rights of people subject to Safeguards, and in turn, to "a long-term restrictive regime accompanied by invasive monitoring", when there are no set procedures for imposing these.

Other matters

In *A Local Authority and others -v- DL* [2012] 3 All ER 1064, the Court of Appeal found that the inherent jurisdiction of the courts to make decisions about vulnerable adults still exists, outside of the Mental Capacity Act 2005. It is there as a safety net for matters not contained in the 2005 Act, and in particular, to assist where a vulnerable adult - who doesn't lack capacity - is subject to constraint, coercion or other influence.

In a case taking place in the European Court of Human Rights, *M -v- Ukraine* (Application No: 2452/04) the court found that a deprivation of a person's liberty is such a serious matter that it must be justified not only by the law in the particular country, but must also be necessary in the circumstances.

Appendix B: Methodology for analysing evidence from visits to care homes and hospitals

We analysed extracts from inspection reports and visits across four categories, specifically:

- Reports for adult social care organisations that had inspections / compliance reviews between 1 April 2011 and 31 March 2012
- Reports for NHS organisations that had inspections / compliance reviews between 1 April 2011 and 31 March 2012
- Reports for independent sector organisations that had inspections / compliance reviews between 1 April 2011 and 31 March 2012
- Reports from visits undertaken by Mental Health Act Commissioners between 1 April 2011 and 31 March 2012.

The aim of the analysis has been to identify and codify all references to the Deprivation of Liberty Safeguards and the Mental Capacity Act to understand what inspectors and Mental Health Act Commissioners have been reporting, and to generate qualitative evidence on the operation of the Safeguards. We identified the total number of inspection reports and Mental Health Act Commissioner visit reports that contained relevant content by conducting a search of all reports for each category of organisation above that had been inspected/visited between 1 April 2011 and 31 March 2012. The following terms were used in this search:

- Deprivation of Liberty / Deprivation of Liberties
- DoLS
- Mental Capacity Act
- MCA.

The paucity of references to these search terms is concerning, and we are trying to understand why the MCA is not more central to services as well as inspection.

Table 3 – Sample of reports analysed

Type of organisation/report	Total number of inspection reports 1/4/11 – 31/3/12	Number of reports that contained search terms (% of total)	Sample: number analysed (% of reports containing search terms)
Adult social care organisations	15,214	5,650 (37%)	599 (11%)
NHS organisations	911	287 (32%)	200 (70%)
Independent Healthcare organisations	1,172	208 (18%)	150 (72%)
Mental Health Act Commissioner visits	1,502	71 (15%)	51 (72%)
Total	18,799	6,216	1,000

The reports were analysed using a pre-defined coding framework; this contained the same themes as used in last year's Safeguards report (2010/11). Reports for each category of organisation were analysed separately but using the same thematic framework to allow cross-comparison. The findings are presented under the following themes:

- Staff training and awareness
- Process of assessments, applications and authorisations
- Use of restrictions or restraint
- Involvement of people who use services in decision-making.

Methodological note

This report presents the qualitative findings from the analysis. In some sections numbers and percentages of reports containing certain types of information or references are given. It should be noted that these are based on qualitative judgements, as the content has been coded thematically. Where present, quantification of the findings aims to provide an indication of the 'weight' of the data, but should not be considered as representative of particular categories of report or provider as a whole.

Appendix C:

External Advisory Group

An Advisory Group of people with expertise in the Mental Capacity Act and the Safeguards advised CQC 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 CQC's monitoring role.

CQC is grateful to the group for the time, support, advice and expertise they have given, and in particular to Rachel Griffiths of the Social Care Institute for Excellence for helping to draft the report.

The members of the group were:

Neil Allen, University of Manchester

James Batey, Court of Protection

Dr Tim Beanland, Alzheimer's Society

Lucy Bonnerjea, Department of Health

Alison Cobb, MH Alliance

Beverley Dawkins, Mencap

Rachel Griffiths, Social Care Institute for Excellence

Peter Hay, ADASS

Roger Hargreaves, MH Alliance

John Leighton, Social Care Institute for Excellence

Andrew McCulloch, Mental Health Foundation

Ann McKay, ECCA

Lucy Series, University of Exeter

Dr Oluwatoyin Sorinmade, Bromley West Older Adult CMHT

How to contact us

Telephone: **03000 616161**

Website: **www.cqc.org.uk**

Email: **enquiries@cqc.org.uk**

Write to us at:

Care Quality Commission

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

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