Care Quality Commission

The operation of the **Deprivation of Liberty Safeguards** in England, 2010/11

March 2012

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 make sure that people get better care. This is because we:

- Focus on quality and act swiftly to eliminate poor quality care.
- Make sure care is centered on people's needs and protects their rights.

Contents

Summary

This is our second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards. Its purpose is to provide an overview of how the Safeguards were implemented and used in 2010/11.

Key findings

- There have been high profile investigations into failures in health and social care which include aspects related to deprivation of liberty. These reinforce the need for, and value of, a system to safeguard the rights of people who lack capacity and are deprived of their liberty.
- We have integrated our monitoring of the safeguards into our mainstream regulatory work, so that it forms part of our inspections of how well care providers are complying with the essential standards of quality and safety.
- Our inspections show that many providers have developed positive practice, notably in involving people and their carers in the decision-making process.
- But, while the number of applications for authorisations under the safeguards rose, there continue to be areas that need to be addressed.
- There is some confusion about what constitutes a deprivation of liberty and this can cause inconsistent practice.
- A 'rump' of providers have still not trained their staff in the Safeguards, two years after their introduction.
- We have identified that there is a need to increase understanding to ensure people's rights are properly protected. Training and guidance, including updates, are likely to be key to developing consistent practice.
- There is a particular gap in information on the role of supervisory bodies which has hindered our ability to monitor the Safeguards. We will take the initiative to address these and in doing so we will broaden our approach to monitoring so as to include other stakeholders more and monitor in partnership with them.
- There continue to be concerns about the complexity of the Safeguards, in terms of content, processes and responsiveness. We will continue to discuss this with the Department of Health as and when our overview of the system enables us to identify areas for exploration.

1. Background

What are the Safeguards?

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

They do this by creating a system for people who are unable to make decisions for themselves about their care, which checks that they are deprived of their liberty only when it is in their best interests and there is no other less restrictive way to make sure they get the care and treatment that they need. This includes ensuring that those caring for them are accountable for the treatment they offer.

The Safeguards can be used for adults aged 18 or over, who are in hospitals or care homes. People who may need the protections offered by the Safeguards typically include those with severe learning disabilities, people suffering from dementia, and people with brain injuries.

For a deprivation of liberty to be authorised a "managing authority" (those registered to provide or manage regulated activities in a hospital or care home) must apply to their "supervisory body" (NHS primary care trust, or local authority). The supervisory body undertakes six assessments, including an assessment of whether deprivation of liberty would be in the person's best interests, and then makes a decision on whether to approve the application.

In the Mental Capacity Act:

- A hospital is "any institution for the reception and treatment of persons suffering from illness, any maternity home, and any institution for the reception of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution"; and
- A care home "provides accommodation, together with nursing or personal care, for people who are or have been ill, have or have had a mental disorder, are disabled or infirm, are or have been dependent on alcohol or drugs".

In other settings, the Court of Protection rules on when deprivation of liberty is appropriate. The Court of Protection also considers appeals, which people who are deprived of their liberty or their representatives have the right to make.

There are some situations in which the Safeguards cannot be used. These include where a person is detained in hospital for treatment of a mental disorder under the Mental Health Act 1983.

Whenever a registered provider applies to a supervisory body for authority to deprive liberty, they are required by lawto notify us of the application and its outcome. [1] They must also notify us if they make an application to the Court of Protection.

CQC's role in monitoring the Safeguards

The Care Quality Commission (CQC) has a duty to monitor the operation of the Safeguards in England. [2] CQC also has the ability, under the same legislation, to provide advice and information on the use of the Safeguards in England. A code of practice to the Safeguards sets expectations for us to monitor the Safeguards through our existing programme of visits, and to report annually.[3]

Our first monitoring report covered 2009/10. We found that even in this first year of using the Safeguards there were examples of good progress and good practice. But there was also a lot of variation, including cases of restraint and restrictions where the Safeguards had not been considered, and low levels of understanding. We identified a need for more guidance that should be easier to understand. We also noted concerns about excessive paperwork when using the Safeguards.

Monitoring the Safeguards, together with our monitoring of the Mental Health Act 1983 (MHA), are our main contribution to the UK's obligations to prevent torture and other cruel, inhumane or degrading treatment or punishment. Those obligations come from a treaty known as OPCAT. [4]

Our monitoring of the Safeguards and the MHA have two key differences.

- Monitoring of the MHA has become well established over the last 30 years: our latest report on it included data on all aspects of the Act, analysis of practice and trends, and direct feedback from individuals who have been detained under that Act. Information enabling us to monitor the Safeguards is clearly improving, but the Safeguards are still only two years old and our monitoring is not yet as mature as it is for the MHA.
- We monitor the MHA through a dedicated programme of visits to meet detained patients, whereas for the Safeguards the code of practice's expectation is for CQC to "monitor the manner in which deprivation of liberty safeguards are being operated, by visiting hospitals and care homes in accordance with their existing visiting programme." [5] In practice, the key difference that this creates is that we monitor the Safeguards as one aspect of broader inspections of the services in which deprivations of liberty may be authorised. Those inspections are targeted to areas where information analysis or observations on site identify questions that need answers, and so they will only focus on the Safeguards where there are specific issues that we are following up.

Appendix 1 sets out in more detail the processes that we used for monitoring the Safeguards in 2010/11.

Our monitoring role is in relation to the Safeguards, which operate in hospitals and care homes. Deprivations of liberty in other settings (which would need to be authorised through the Court of Protection rather than the Safeguards), are outside of our direct monitoring remit. We have some information on these cases as, in most cases, we also regulate and inspect the provider under the Health and Social Care Act 2008. However, we are often not able to observe directly the circumstances in which a deprivation has occurred, because we have no right of access to a person's private dwelling.

We have become aware through liaison with Ofsted that a number of children's homes have applied to the Court of Protection for authority to deprive liberty. These cases are also outside of our direct monitoring remit, and the care service is not within our regulatory remit, so we do not have a full view of how often deprivations of liberty occur in services for children and young people. There is clear guidance on obtaining authorisation to deprive a child or young person of liberty set out in the Code of Practice on the Safeguards. [6] This makes clear that there are in general three possibilities for lawful deprivation of liberty of someone unable to make decisions for themselves on their care:

- Through the Safeguards, authorised by a supervisory body, for people aged 18 or over in a care home or hospital.
- With authorisation by the Court of Protection in other circumstances.
- For the specific case of children and young people under 18, alternative safeguards must be considered, such as those allowed for in section 25 of the Children Act 1989 or in the Mental Health Act 1983.

The context for our monitoring

The Safeguards have been in operation for two years, and so are still relatively new.

There continue to be incidents and concerns which indicate the need to protect people's rights when their liberty is deprived. Some of these have caused public outrage: Winterbourne View (an independent learning disability hospital) and Mid Staffordshire NHS Foundation Trust are two particularly high profile cases which include concerns about restraint and other potential deprivations of liberty of people in situations of vulnerability. Although they are not always on the front pages, there also continue to be a number of lower profile cases which relate to deprivation of liberty (such as concerns about the use of anti-psychotic medication in care homes for people with dementia).

Case by case, the Court of Protection's rulings are extending understanding of how to apply the Safeguards. Some key recent cases are summarised in Appendix 2. While the judgements are clearly to be welcomed, it is fair to say that there is still significant complexity in understanding what constitutes a deprivation of liberty and when to apply the Safeguards. There are also challenges for both managing authorities and supervisory bodies in keeping abreast of the latest judgements.

In addition to the complex content of the Safeguards, there are concerns about the processes for using them and for appeals. We noted these concerns in our 2009/10 report and they are still current. They centre on administrative procedures, costs and accessibility, and the impact that these could have on the Safeguards' effectiveness both as a system and in individual cases.

All managing authorities are now within a single regulatory system under the Health and Social Care Act 2008 (our previous report on 2009/10 straddled the end of the former systems and establishment of a single new one). However, further change is anticipated in the health and social care system as NHS primary care trusts will be abolished in April 2013, and local authorities will assume responsibilities as supervisory bodies for hospitals as well as for care homes.

2. Our findings: patterns of use of the Safeguards

In this section, we present data on use of the Safeguards in 2010/11. These data come from national returns made by supervisory bodies to the NHS Health and Social Care Information Centre (IC), and our own data which we collated from notifications made to us by managing authorities.

For the first time, we have undertaken an analysis to compare these two sources of data. This thematic review was undertaken primarily to increase the value of data for our inspectors, enabling them to see comparisons in use of the Safeguards by area and types of establishment, which they can then use to provide context for notifications (or lack of notifications) that they receive from individual care homes and hospitals.

Key points

- As in 2009/2010, there is large variation in rates of use of the Safeguards by region. There is no benchmark of what rate should be expected.
- There is under-reporting by registered providers of notifications that they are required to make to CQC.

NHS Health and Social Care Information Centre (IC)

The IC collects and summarises information provided by PCTs and local authorities every three months.

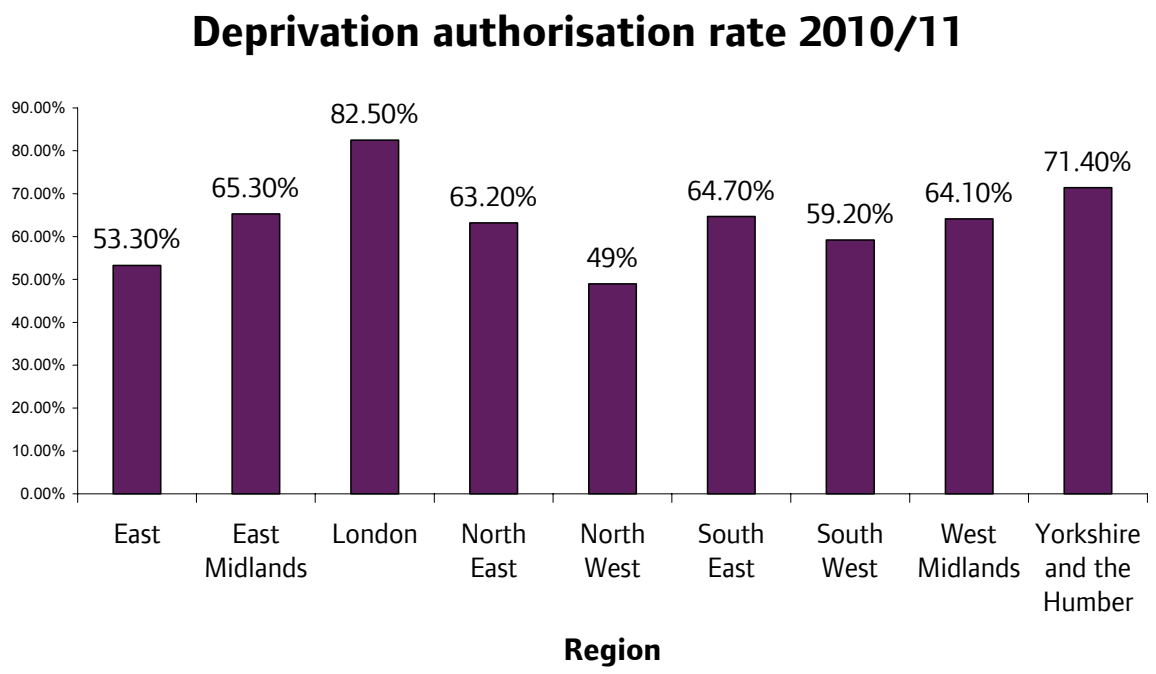
Between April 2010 and March 2011 8,982 applications for assessment were made by managing authorities, of which 4,951 (55%) resulted in an authorisation for a deprivation of liberty being granted. This compares with the total for the previous year (2009/10) of 7,157 for which 3,297 (46%) applications were authorised. This is consistent with the steady increase in applications seen in the IC's quarterly data.

Although the number of applications rose significantly in 2010/11, this was still much lower than the number anticipated by the Department of Health in their planning assumptions for England and Wales, which predicted 18,600 applications. In contrast, the percentage of applications granted in 2010/11 (55%) was once again significantly higher than the 25% expected by planners.

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

2010/11 figures continue to show regional variation in numbers of applications made to supervisory bodies. The East Midlands continued to have the highest percentage of applications across the country (18%) and the North East continued to have the lowest (6%). When taking population figures into account, the East Midlands also had the highest rate of applications per capita with 46 per 100,000 population. This is more than double the average rate for England of 22 per 100,000 population (see figure 1).

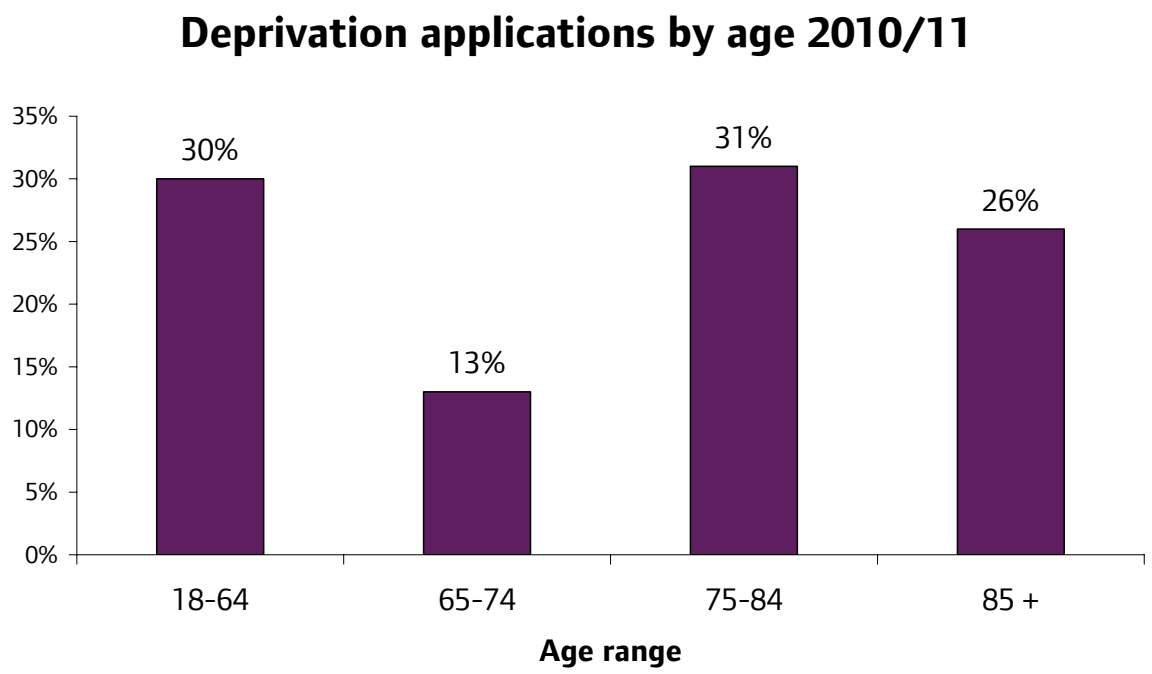
Figure: 1



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

In 2010/11 figures also continue to show that the majority (69%) of applications were for people aged 65 and over. Indeed the rate of applications per 100,000 population was eight times higher for the 65 and over age group, compared with the 18 to 64 age group (see figure 2).

Figure: 2



Supervisory bodies are required to record information about the disabilities that contribute to a person needing to be assessed. In quarter 1 2010/11 more than one category could be applied to a single person's application. From quarter 2 2010/11 onward, only the person's primary disability (the reason the application is being made) is recorded on the application. Of the total applications completed in quarters 2 to 4 of 2010/11, 66% were for people with a disability categorised as a 'mental health issue', 20% for people with a 'physical disability, frailty and/or temporary illness', and 14% for people with a learning disability. Specifically, the dementia sub-group of 'mental health issues' accounted for 52% of all applications making dementia the main reason for deprivation of liberty applications.

The proportion of applications received for people from each ethnic group was consistent with the make up of the population as a whole, except in the Asian or Asian British group where the proportion of applications was lower.

There were a number of reasons why authorisation was not granted in 2010/11. In the vast majority of cases (81%) this was because the 'best interests requirement' was not satisfied (including whether what was being proposed was actually a deprivation of liberty). This was followed by the mental capacity requirement not being met (10%), the eligibility requirement not being met (6%) and the mental disorder requirement not being met (2%).

CQC's thematic review of applications and notifications

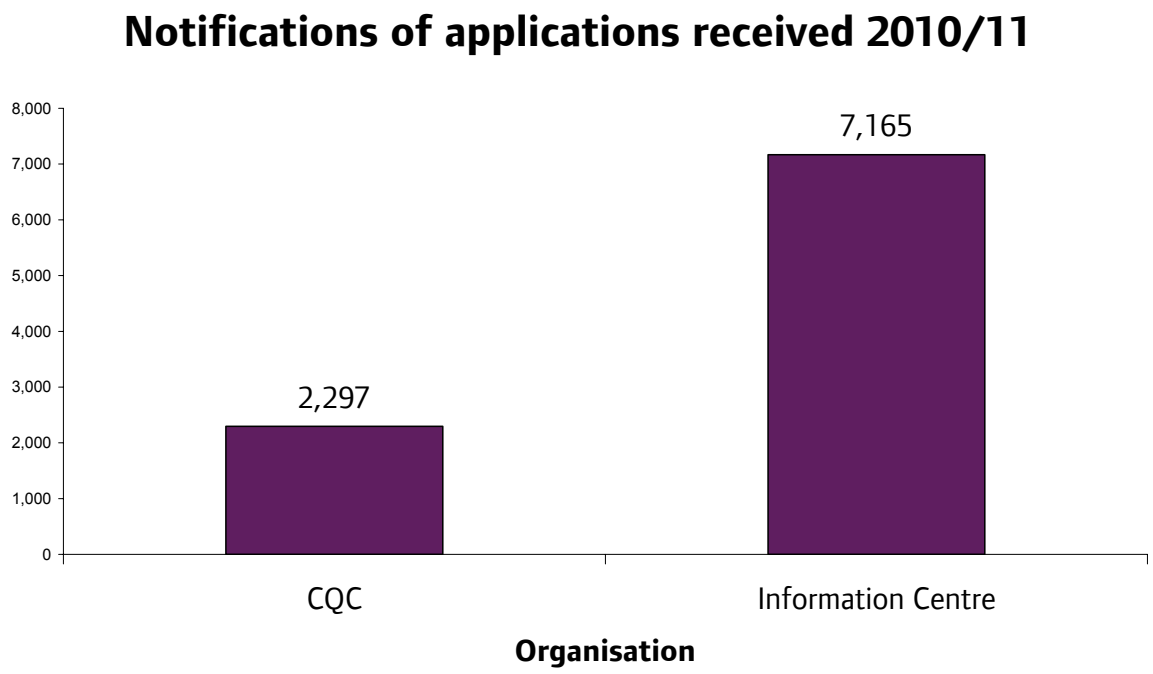
This was an internal review to equip inspectors with more information on use of the Safeguards and draw comparisons between the CQC and IC notification data.

At the point of developing our review two data sources were available covering two different periods. We chose a nine month period between October 2010 and June 2011 that would be covered by both data sources.

Managing authorities, in accordance with the registration regulations, are required to notify CQC when they have made an application under the Safeguards.

The review has shown there was a large shortfall in the number of notifications received by CQC compared with IC figures. We received notification of 2,297 applications over a nine month period from October 2010 to June 2011 compared to the 7,165 applications to supervisory bodies as reported to the NHS IC over the same period (see Fig 3). We have developed an approach to improve the number of notifications we receive, this is discussed in section four of this report.

Figure: 3

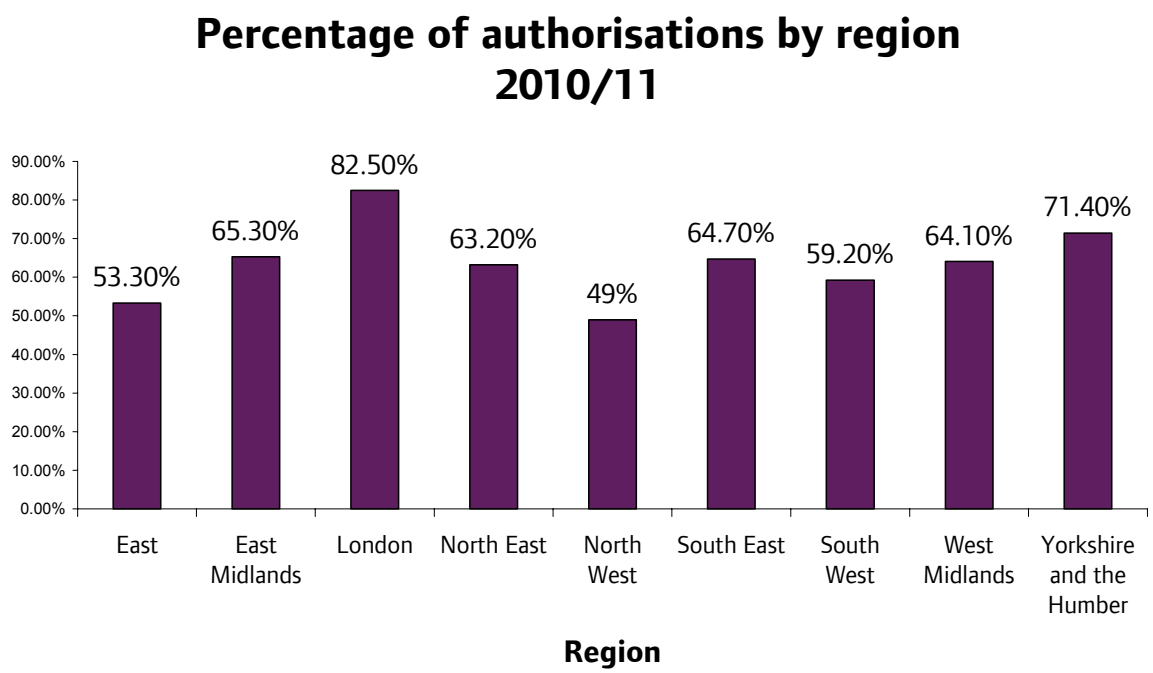


CQC's notifications data show a similar picture to the IC's data regarding the split between social care and health care applications. Adult social care settings submitted 1,600 notifications about an application to deprive someone of their liberty (70%), NHS settings submitted 635 notifications (28%) and independent healthcare settings submitted 62 notifications (3%).

Notifications to CQC also showed evidence of regional variation. The East Midlands saw the highest number of notifications per capita with 6.6 per 100,000 population, while London saw the lowest with 2.3 per 100,000 population.

CQC's figures also suggest regional differences in the rate of authorisation across the country. As a whole 64% of applications were authorised and 36% rejected. London saw the highest rate of authorisation with 82.5% while the North West had the lowest at 49% (see figure 4).

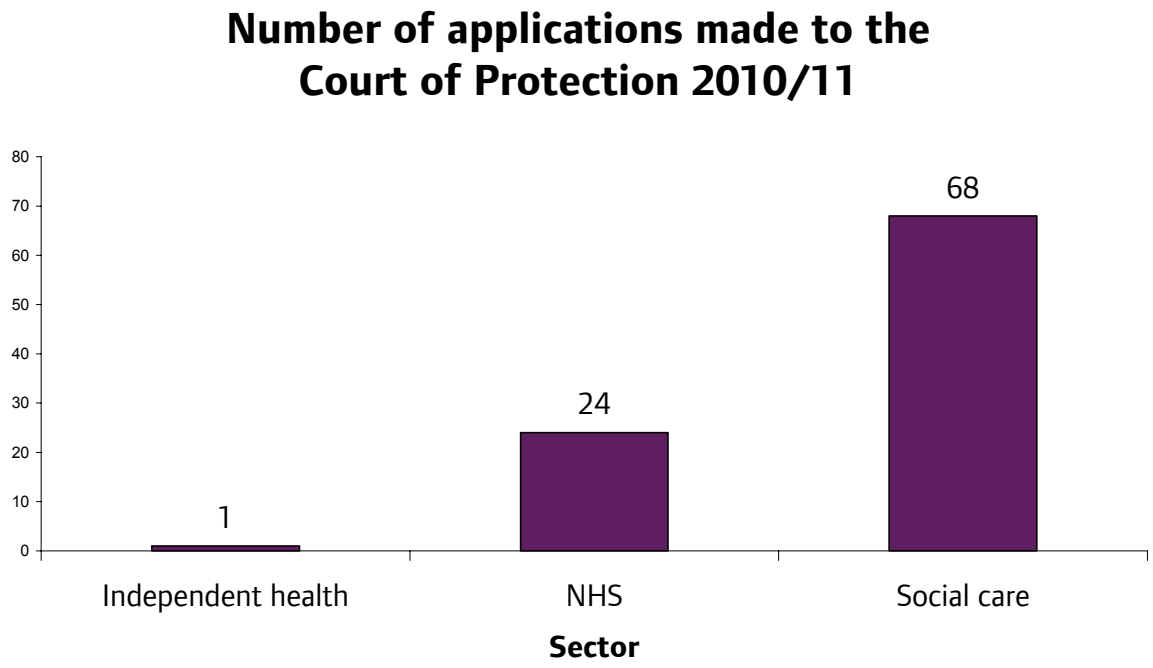
Figure: 4



There was a difference in the approval of applications between health and social care. In healthcare 56% of applications were authorised whereas social care had a 68% authorisation rate.

We have very limited information on Court of Protection issues and do not have a duty to monitor them directly. However providers are required to notify CQC when they apply to the Court of Protection and over the nine month period we looked at CQC received 93 notifications about applications to the Court of Protection (see figure 5).

Figure: 5


Number of applications made to the Court of Protection 2010/11
80
70
60
50
40
30
20
10
0
1
24
68
Independent health
NHS
Social care
Sector

3. Our findings: inspections

In this section, we present information from inspections in 2010/11 of:

- Care homes
- NHS hospitals
- Independent hospitals (divided into 'acute (general) hospitals' and 'other independent providers')
- Shared Lives and supported living schemes.

We reviewed a sample of 1,212 inspection reports distributed across all regions. The themes that we drew from these were:

- Staff training and awareness
- The process of applications, assessments and authorisations
- Involvement of people who use services in decision-making
- Use of restrictions or restraint
- Other less frequent themes: safeguarding and medicines.

We also reviewed the reports of all 1,552 visits in all regions by Mental Health Act Commissioners in 2010/11. Of these, 32 reports referred specifically to the Safeguards or deprivation of liberty, and we analysed these further. Mental Health Act Commissioners' visits are at ward rather than hospital level. They focus on the MHA but occasionally, in checking people's experience of being detained, they will come across issues affecting informal patients such as deprivation of liberty and the Safeguards which need to be recorded. Findings in these reports fit under some, but not all, of the themes above.

Where we reviewed reports of inspections of Shared Lives and supported living schemes, we checked for reference to the Mental Capacity Act 2005 and deprivation of liberty. The Safeguards do not apply in these settings but deprivation of liberty may still occur (with authority from the Court of Protection).

3.1 Staff training and awareness

Key points

- Inspections suggest a continuing and significant 'rump' of providers of all types who have still not fully trained their staff in the Safeguards. This is similar to our finding in 2009/2010.
- Where training is given, providers should check that it covers all the appropriate staff and that knowledge is kept up to date.

Care homes

In our sample of inspections of care homes, in reports which referred to training on the Safeguards of the Mental Capacity Act (MCA) a clear majority recorded that some or all staff had received training and had some awareness of the Safeguards and/or the MCA. The proportion was around two-thirds in reports from the first half of the year, rising to four-fifths in the second half, which may suggest an improving trend.

The level and grade of staff receiving training in these areas varied. In some cases staff and managers had received training, while in others only managers had. A common trend was that while some staff had received training, others had not but it was planned. Some care homes had struggled to access training for all staff.

The training was often provided in context with other topics relevant to day to day work in the care home, such as dementia care, managing challenging behaviour, consent procedures or promoting people's rights, safeguarding vulnerable adults or equality and diversity. Sometimes, staff had received training when the Safeguards were first introduced but it had never been updated. Given the continuing developments in case law, training and guidance cannot appropriately be seen as one-off events. Furthermore, even where training had taken place, in a number of cases our inspections report that staff were not confident in their understanding of the Safeguards. This reinforces the need for regular update training and guidance to be considered.

Some care homes in our sample either still planned to do training in the future or had not organised any training. In our monitoring report for 2009/2010 we found that 29% of the inspections which looked at training found that care homes which had not yet trained their staff. In 2010/2011, around a third of reports from the first half of the year that mentioned training on deprivation of liberty or mental capacity, and a quarter from the second half of the year, recorded either that there had been no training, or recorded plans for future training. Although the methodology used in each case was different, so direct comparisons cannot be made, this does suggest a continuing and significant 'rump' of a similar size to that in 2009/2010, where the care homes may not be appropriately engaged in ensuring that all relevant staff are trained in protecting people's rights under the Safeguards. Providers have had ample time to put training in place, and any continuing failure to check and ensure staff competence in the Safeguards after two years of their operation would be a serious omission.

"Given that the people who live at the home experience some degree of cognitive impairment we enquired about Mental Capacity Act training and in particular Deprivation of Liberty (DOL) training. The local area commissioning team recommended in November 2010 that the manager and deputy manager undertake this training. We were told that they plan to attend DOL training but dates for the training have yet to be established."
Care home, North West

"Most of these staff had received the training over two years ago and there was no record included in the staff training matrix to show that they had received further training since that time."
Care home, East Midlands

NHS hospitals

From our sample of inspections, in most cases we could see that some or all staff had received training or had some awareness of the Safeguards or MCA. Within this, rates of training ranged from 20% of staff to 100% of staff, although many reports gave no specific figures or proportions.

In many instances training on the Safeguards was run as a specific module and not as part of induction sessions, whereas many would argue that at least an awareness of deprivation of liberty as part of human rights, and of the existence of requirements for safeguarding those rights, are essential for all care staff.

A few reports reference the impact of staff training on the Safeguards in the NHS, for example with one provider reporting a rise in the number of Safeguards referrals since training was provided. This indicates that training can be effective in providing staff with the ability to recognise where an application may be necessary.

Where training had not yet taken place, it was sometimes planned but in most of these cases our reports recorded no training and no evidence of plans for it. Just as with care homes, this suggests that there are still some NHS hospitals failing to engage in ensuring that their staff are appropriately trained to protect rights under the Safeguards.

Independent hospitals

Our sample of inspection reports showed evidence of training on obtaining consent and conducting mental capacity assessments, but no specific references to training on the Safeguards in independent acute hospitals.

In independent mental health and learning disability hospitals, reports do comment on Safeguards training, and the picture is similar to that for the NHS. Training in the Safeguards may be perceived as a 'specialist' subject meriting separate training, or for only some staff and not all inspection reports record that training has taken place. However, there was also evidence in this sample of reports of independent healthcare staff being confident, in terms of knowledge and awareness, in their use of the Safeguards.

Overall, it is difficult to draw any conclusions about training and awareness in independent healthcare providers from this sample of inspection reports. It is worth noting however that since 2010/11, CQC has started a programme of inspections to all independent learning disability hospitals which should allow us to understand better how well this sector is ensuring that staff protect rights under the Safeguards.

Shared Lives schemes and supported living schemes

The inspection reports that we reviewed indicate that only a small proportion of these providers have not yet organised training in the MCA or deprivation of liberty. However, as with all of the other types of providers, the reports indicate that training may be limited to only managers or a proportion of staff.

3.2 The process of applications, assessments and authorisations

Key points

- Across each sector, we found encouraging positive examples but also areas of concern, indicating that overall practice is variable and not well embedded.
- Some hospitals are making few or no applications to deprive liberty, but there is currently no benchmark to know what an expected level of applications would be.

Care homes

Our sample of inspections suggests considerable variation in practice. Good practice examples included the involvement of relevant professionals, such as advocates and representatives from the local authority, and clear documentation. Poor practice included out-of-date authorisations and restrictions placed on residents with no evidence of assessments or applications, as well as inconsistencies between the rights limited on the application, and those limited in practice by care home staff. In these cases, we may require improvements or start taking enforcement action.

"We viewed a very detailed Deprivation of Liberties (DoLS) Assessment undertaken by the service in conjunction with the local authority. The assessment is reviewed every six weeks and updated if changes have occurred. Within the assessment it was clearly evident why certain restrictions are implemented and in place for the protection of the person and other people using the service living in the home. [...] Due to the limited understanding demonstrated by people living [here], family social workers, staff and any significant others have been involved in the assessment process."
Care home, London

"Although, the home had requested DOLS authorisation, the authorisations received were not always consistent with the request. We saw that staff limited rights which were not specified as conditions within the authorisation received. […] Care plans were developed for people. However, the person's ability to make decisions or the deprivations of liberty restrictions imposed was not included."
Care home, South West

NHS hospitals

Our sample of NHS hospitals also showed variations in practice. Examples included joint working and joint training with local authorities, multi-disciplinary assessments involving professionals, patients, their carers and advocates in decision-making, and routine assessments of mental capacity. Other examples included poor or incomplete documentation

of assessments of mental capacity, departures from policy resulting in fewer assessments of mental capacity, and a general lack of confidence in using the Safeguards or assessing capacity among staff and ward level leaders.

Only a small number of NHS hospitals in our sample had made any applications for deprivation of liberty (less than 5%). The low number of referrals could indicate that staff are not using the Safeguards in all cases where they may be required, but there is no benchmark available to compare it against in order to know if it is higher or lower than expected.

"Staff had referred the patient to the social worker for an urgent best interest assessment under the MCA and subsequent application for DoLS. The hospital matron showed us records of comprehensive communication with all parties involved including the person's relatives. In this case, a person was deprived of their liberty only after a "best interests" assessment and the involvement of relevant member of the multidisciplinary team."
NHS hospital, East Midlands

"We looked at three care records to establish if it is recorded that people had their capacity assessed to support them making important decisions about treatment. We saw that this was not the case and that when people lacked capacity to make important decisions, a best interest meeting was not always undertaken promptly. In one instance a best interest meeting had been identified as needed as a matter of urgency, this had taken a month to organise."
NHS hospital, South West

Independent hospitals

In independent hospitals our sample of inspections also indicated that the Safeguards had only been used in a very small number of cases. We found both positive examples (for example, in assessing capacity to consent) and negative examples (for example, records of applications but not of their outcome).

CQC's programme of inspection in 2011/12 to all independent learning disability hospitals should provide further understanding of the situation in that sector

Visits by our Mental Health Act Commissioners

Commissioners' visit reports occasionally ask providers (in the NHS or independent sector) to consider the Safeguards. Where they do so, this information is shared with compliance inspectors and can trigger an inspection under CQC's regulatory powers.

The issues that Commissioners raised in relation to the Safeguards concerned information about rights and entitlements, record keeping, and cases where patients' capacity to consent had not been assessed. We cannot generalise from these about specific aspects of practice. They do however indicate a general need for practice in using the Safeguards to develop further even in secure settings where staff might be expected to be very aware of issues of deprivation of liberty, human rights and the legal frameworks around them.

3.3 Involvement of people who use the service in decision-making

Key points

- Our sample of inspections highlighted people's involvement in decision-making, in all sectors. Overall, this is encouraging and we recognise positive practice.

Care homes

Our sample of inspections shows positive practice, including access to Independent Mental Capacity Advocates (IMCAs) and involving people using the service and their relatives to explore options before resorting the procedures to deprive liberty. It included cases where there was uncertainty over whether a specific course of action would constitute a deprivation of liberty, and the principles and approach of best interest assessments were followed nonetheless.

In reviewing these reports, it appears that the structure of the current inspection regime checks and records people's involvement in consent and decisions more explicitly than was the case under the former Care Standards Act system. It will be important to maintain this focus as there is not universally positive practice.

"We looked at the care plans of five people using the service and we saw that although there were capacity assessments in place, these were not task specific and were more a general assessment about whether the person had the capacity to make decisions. We spoke with the manager and deputy manager about the lack of task specific capacity assessments and they told us that there had been a lack of understanding about the Mental Capacity Act"

Care home, East Midlands

NHS hospitals

Our sample of NHS hospitals had good procedures for involving and supporting people in decision-making, which we saw were in use for those unable to give consent. From these inspection reports, our only qualification in recognising this positive practice is that there were some indications that this support may not always be matched by an ability to recognise what constitutes a deprivation of liberty and when the formal Safeguards procedures are required. In other words, people are clearly being involved in decision-making but there could be cases where decisions should involve the Safeguards but do not because staff are uncertain about what constitutes a deprivation of liberty.

Independent hospitals

Our sample of inspection reports suggests a very similar picture to NHS hospitals of generally good involvement (although with the same caveat that we cannot be sure that providers are actively determining whether their decision-making on behalf of a patient lacking capacity

could constitute a deprivation of liberty). The reports do also note however a particular range of positive practice that we saw to support people lacking capacity, including , having policies in place, consenting procedures appropriate to the individual, updating staff training, and providing information and access to advocacy

Shared Lives and supported living schemes

Almost all of the schemes in our sample of inspections showed good involvement of people in decisions about their care and a strong assumption that clients possessed the capacity to make their own decisions, unless it could be determined otherwise.

3.4 Use of restrictions or restraint

Key points

- Our sample of inspections show that widespread improvement is needed in recognising when restrictions or restraint amount to a deprivation of liberty and the Safeguards must be used.

Care homes

About a tenth of care home inspections in our sample mentioned the use of restrictions or restraints. The majority of uses of restraint concerned locked doors or the use of bed rails.

In some care homes these practices were in operation without any consideration of whether they might constitute a deprivation of liberty. The use of bed rails was a particular example of where some care homes did not consider possible deprivation of liberty issues, others decided it did not constitute a deprivation of liberty, and others made applications to supervisory bodies. This will of course vary appropriately from case to case, but the impression is that there is a lack of consistency and confusion about what constitutes a deprivation of liberty.

"We found that the home had taken action to look into whether the wearing of devices in the form of pendants around people's necks during the day was a deprivation of their liberty. The pendants can be programmed to alert staff to people's whereabouts and remind them of when care or support is needed, for example when to administer a medicine."
Care home, South East

We found examples of positive practice including clear and accessible restraint policies, well-documented risk assessments, and information in care plans concerning the use of equipment and practices that involve restricting liberty, such as bed rails, wheelchair straps, and Kirton chairs.

Where there was poor practice, the two most common features were either that staff had not asked professionals from their local supervisory body and IMCAs to get involved, or the staff were not trained in the Safeguards and were unaware of whether restrictions or restraints might constitute a deprivation of liberty. For example, we found several instances where

doors were locked so as to make it easier to manage the behaviour of residents when short staffed, without any consideration of the legal framework for deprivation of liberty.

"Some doors are kept locked and there were a number of keypads on doors which many people in the home cannot use. While this may be necessary to ensure some people remain safe, there was no evidence that this practice had been assessed to decide if this amounted to a deprivation of liberty for some people."
Care home, South West

"One person had been unhappy about the use of rails and was in danger of falling over them as she liked to use her bedside table; however rails had still been used. There was no indication that the Mental Capacity Act and associated legislation had been considered in light of this person's rights."
Care home, West Midlands

NHS hospitals

There was reference to the use of restrictions or restraints in fewer than half of the NHS hospitals in our sample. Most of these did not refer to the Safeguards or consideration of legal aspects. In some cases inspectors felt that people may have needed protecting with the Safeguards. Examples of the types of restraint or restriction reported were: use of a 'fall out' chair restricting a patient's movement; use of bed rails for people lacking capacity to consent; locked rooms with use of keypads for access; and rapid tranquilisation restraint.

Overall, the reports indicate variation across NHS hospitals, and in some instances there is still a lack of understanding amongst staff about what constitutes a deprivation of liberty, and how and when the Safeguards apply.

Independent hospitals

There were no references to restrictions or restraint in our sample of independent acute hospital inspections.

In independent mental health and learning disability hospitals, a few reports raised concerns that patients were being deprived of their liberty, particularly through having their movement restricted, without having had a proper assessment or authorisation.

Overall, the reports indicate that some staff in independent mental health and learning disability hospitals are unaware of when restricting a patient may constitute a deprivation of liberty and require authorisation through the Safeguards.

For example, in one case the lack of regard to the Safeguards appeared to be systemic and on-going. We found a patient receiving care at an independent hospital on a voluntary basis but staying on a locked ward and only able to leave with a staff escort. As well as this day-to-day practice, presumably involving a whole team of staff in potentially depriving liberty, there was a documented care plan to prevent the person from "absconding" from the hospital. However there was no evidence that the patient's mental capacity had been assessed or that

anyone had raised concerns over whether this might amount to a deprivation of liberty requiring the Safeguards.

"We could not find any records to demonstrate that his capacity had been assessed or any record of the decision that it was in the best interests of the patient to restrict his liberty."
Independent healthcare provider, North West

Visits by our Mental Health Act Commissioners

One of the main issues identified by Mental Health Act Commissioners was making sure that informal patients on locked wards and who may lack capacity understood their rights and were given adequate support and information about leaving the ward if they wished. The Commissioners also drew attention to inappropriate reasoning to justify the use of restriction and restraint, and poor record-keeping of the reasons for use of restraint.

Overall, Mental Health Act Commissioners' reports indicate that the situation of informal patients who may lack capacity in secure wards continues to require checks, so that measures which may be authorised for detained patients are not applied to these informal patients without proper authority.

Shared Lives and supported living schemes

We found very little information about actual use of restrictions or restraint in this sample of reports. Several providers operate a 'no restraint' policy in this type of service and clearly avoid measures that could potentially amount to deprivations of liberty. Others had given consideration to the use of restrictions, restraint and whether such measures could constitute a deprivation of liberty, even if they were not currently needed.

3.5 Other less frequent themes: safeguarding and medicines

Key points

- We do not offer any conclusions in these areas but they may need to be kept in view for future monitoring.

Care homes

A theme that came out in our sample of inspection reports was positive practice in considering the Safeguards and mental capacity in managing safeguarding concerns. This particularly included positive findings in relation to including the Safeguards in risk assessment processes, partnership working and training on safeguarding.

We also found mental capacity and the Safeguards being considered in relation to medicines. There were a few examples of instances where care homes had used mental capacity assessments and best interest meetings to decide if the administration of medicine without

patients' permission was appropriate. But there were also cases where no mental capacity assessment had been undertaken and residents were given medicine without their knowledge and without any discussion with families and relevant professionals. We found only one example where a deprivation of liberty application had been made in relation to the covert administration of medicine.

We cannot draw any conclusions from our sample but these may be areas to keep in view for future monitoring.

NHS hospitals

We also found examples where the Safeguards were considered in NHS hospitals in relation to safeguarding. These also seemed a positive theme. For example, there were cases where specific safeguarding incidents had prompted providers to put improvements in place, including in relation to the Safeguards.

"The ward manager told us that issues relating to the Mental Capacity Act and the Deprivation of Liberties Safeguards were now discussed for each patient at each weekly ward review. We found that the trust had successfully completed all actions set out in their action plans and had introduced ongoing monitoring to ensure continued compliance."
NHS Hospital, South East

4. Conclusions and next steps

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

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

Working with stakeholders

We are clear that our ability to monitor the Safeguards is improving year on year, but after two years of their operation there remain important gaps in information. Those gaps limit our ability to comment on the Safeguards' effectiveness overall. It is not within our power alone to address this, but nonetheless we intend to take the initiative – in particular by broadening our approach to monitoring so as to involve other stakeholders more.

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

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

Developing our monitoring approach

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

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

Further embedding the Safeguards in compliance monitoring

The Safeguards are no longer new and both providers and supervisory bodies have had ample time to train staff and develop policies. The Safeguards are explicit in the essential standards of quality and safety that we monitor in inspections, and which we can follow up with our enforcement powers.

Our monitoring of the Safeguards in managing authorities is integrated into our compliance monitoring, alongside other essential standards of quality and safety. We are undertaking further work to ensure that our inspectors can consistently identify where there may be concerns about the Safeguards and understand how to respond:

- Our thematic review has increased the usefulness of information available to inspectors.
- We have developed and issued further ongoing training and resources for our staff specifically on the Safeguards and mental capacity.
- We have updated guidance for our staff and for providers and will work with stakeholders to consider how to coordinate further updating with future guidance that others may issue (for example in the light of developments in case law).
- The new approaches to inspection that we are currently piloting – designed to increase the proportion of inspectors' time physically in care services – require that the Safeguards should always be explicitly considered when planning inspections of care homes or hospitals. We have updated our information system so that, if the pilot is adopted, there will be the ability to track and ensure that the Safeguards are always considered, and to see how often that follows through into inspection.
- We have identified national and regional operational leads for the Safeguards, and created a new national policy post on mental health and mental capacity legislation.
- We are increasing the information flows between MHA visits and compliance inspections, including more joint visits, so that where MHA Commissioners identify possible deprivation of liberty for informal patients, it can be followed up under our compliance powers if it is beyond our MHA remit.

We intend that these steps will ensure that the Safeguards have visibility and priority in our inspections. We will be looking to engage with external stakeholders so that they can help us to keep it under review and identify further opportunities for improvement.

Improving our information on managing authorities' applications and authorisations

The thematic review that we have carried out of notifications and IC data is a significant improvement in information that can support monitoring of compliance and robust inspection. We intend to repeat this review in 2012, so as to update it as new information becomes available. We will keep under consideration whether we can repeat the review in future years. Even if we do not always have sufficient resource to repeat it nationally, now that the review methods have been developed, we will have the potential to carry out the comparative analysis at regional or area levels, where a priority is identified locally.

The other area where we will focus our effort on improving information about the Safeguards in managing authorities is notifications. Providers are required by law to make notifications to us whenever they make an application to use the Safeguards. The important value of notifications is that they are timely: where it is warranted, a notification can trigger an immediate inspection, instead of waiting up to 12 months for IC data to identify where we need to inspect. However currently, for every three applications for deprivation of liberty reported to the IC, we only receive one notification. Our approach to improving this will have two strands.

Submission of notifications

We will make it significantly easier for managing authorities to make notifications to us. We have asked the Department of Health to amend the relevant regulations, so as to allow us to specify a common format for notifications and to simplify the requirements for notifying the Safeguards. The Department has consulted on this and we hope that final proposals will be put to Parliament early in 2012. Subject to Parliamentary approval, we will then introduce an online system with a simplified electronic form and require notifications in that format.

Enforcement

We have consulted on a revision to our enforcement policy, and will issue a final version in 2012. The draft enforcement policy makes clear that we have a range of proportionate powers, and that we will use them where appropriate. Failure to notify is a less serious offence than direct harm to service users, but our enforcement powers particularly include proportionate responses for low level offences: for example, we have powers to issue fixed penalty fines. Up until now, we have not been able to identify and follow up providers who do not make notifications to us but, by comparing our notifications from managing authorities to data that the IC collects from supervisory bodies, the method that we developed for our thematic review of data on the safeguards can now enable us to do just that. Our enforcement policy will signal our willingness to use the full range of our powers, from low level to major, and set out the framework for doing so proportionately.

Developing our ability to monitor the overall Safeguards system

Although information on managing authorities continues to improve, by itself that is not sufficient to advise on the overall effectiveness of the Safeguards. We have no routine information on appeals, use of the Court of Protection (including where liberty is deprived in settings other than care homes and hospitals), or access to advocacy and support, for example. We do not have the range of direct feedback from people subject to the Safeguards or from their carers, that we have in our MHA monitoring. And with on-going change in PCTs and local authorities, and in their arrangements for performance assessment, we do not have comprehensive information on supervisory bodies or assurance that it will be available in the future.

It is not CQC's responsibility to resolve all of these issues, and we do not intend to address them alone. However, we believe that we should do what we can to develop information across the whole system related to the Safeguards because there continues to be public debate about the benefits and shortcomings of the system, and there is limited ability to address the issues raised without better information. We are therefore using this report to acknowledge the desirability of better information and the role that we might play in developing it. Our approach to exploring this will be to engage with a range of stakeholders to see if we can pool existing information and develop information flows collaboratively.

The area of particular priority for us is to improve our access to information on supervisory bodies, as their role is clearly part of our statutory monitoring duty. We would like to better understand the variations in use of the Safeguards between areas and to gain a view of local authorities' roles in the Safeguards more broadly, including how they will take on new

relationships and assessments for the Safeguards in the healthcare sector. However, local authorities are already subject to many information requests from the IC and others, and we do not intend to add to those. A new system of collaborative review is in development, which may have regard to local authorities' roles as supervisory bodies, and it would not be appropriate for us to act other than in close coordination with that. Finally, the Safeguards are just one of many areas in which we may routinely engage with local authorities; if only for practical purposes, anything that we do on the Safeguards must be within the context of the range of our interactions with local authorities.

We are therefore planning a pilot in 2012. The pilot will ensure that we can get more information but allow time to make sure that it fits with other information collection systems. Its aim will be to help us define information on supervisory bodies that is both valuable and practical. We will then explore whether there are ways to develop a systematic information flow, which we expect should be possible within a particular objective of not creating additional, new systems. For example, we might explore accessing information as a by-product of local authorities' collaborative reviews, whether it might be incorporated into an information sharing portal that we are investigating with the Association of Directors of Adult Social Services, or whether it might be included in information processes already set up for safeguarding and vulnerable adults. Other options may well also be identified, but none of these is likely to be immediate or even short-term. Therefore, in the mean time, we will design the pilot so that it also identifies issues that our compliance managers (who manage a team of inspectors for a given area) may cover in the regular meetings that they already have with local authorities.

Appendix 1 – How we monitored the operation of the Safeguards

How we monitored managing authorities in 2010/11

From April 2010, the Care Quality Commission introduced a new registration system across the care sector. Registration is a licence to operate. To be registered, all health and adult social care providers must by law show that they are meeting essential standards of quality and safety, which are set out in the Health and Social Care Act 2008 and the Regulations made under it.

We regulate about 21,000 care providers operating services from around 35,000 locations, and we aim to ensure that in each of these settings, the essential standards are still being observed. Our monitoring work focuses on the essential standards that most directly relate to quality and safety and people's experiences of care. We monitor compliance in a number of ways including regular inspections. These inspections can be a routine check, or in response to a specific concern. We currently inspect in the region of 1,000 locations every month.

In an inspection, we focus on observing care being given and talking to people who receive care as well as staff. We also seek information from people who use services, public representative groups and organisations such as other regulators.

We have produced guidance about how services can demonstrate they are meeting the essential standards, which we have set out as the 'outcomes' that people who use care services should receive and experience where legal requirements are being met. Four of these are firmly related to issues around involving people and where necessary their supporters in decisions about their care:

- Outcome 1: Respecting and involving people who use services
- Outcome 2: Consent to care and treatment
- Outcome 4: Care and welfare of people who use services
- Outcome 7: Safeguarding people who use services

We have published guidance for providers about complying with the essential standards. The prompts in this guidance assume that people using services have the capacity to make their own choices and decisions independently. [7] We make it clear that, where this is not the case, providers must support the person in line with:

- The Human Rights Act 1998
- The Mental Health Act 1983
- The Mental Capacity Act 2005
- The Children Act 1989 and Fraser competency.

When managing authorities make an application for deprivation of liberty, they are required to notify us of this, and of its outcome. These notifications provide us with timely information that we can act on, and enable us to monitor use of the Safeguards at the level of individual care homes and hospitals (as opposed to national data, which do not go below area level). They are therefore important information. However, we have observed that – although failing to send us notifications when required is a breach of the Health and Social Care Act

registration regulations – some providers are not making notifications about applications for deprivation of liberty as they should. We have therefore started to develop measures to improve this situation, which are described later in this report.

In our first monitoring report on the safeguards in 2009/10, we noted that not only were the Safeguards themselves new (as that was their first year of operation), but that our systems for monitoring care homes and hospital were also new (they were introduced during that year). We acknowledged that our own inspectors' awareness and understanding of the safeguards could not at that stage be consistently assured.

Since then, we have developed additional training for all inspectors. We have provided further internal guidance, and produced a resource pack for managers to use to structure regular discussion and reflection of the Safeguards in inspection teams. These measures have been coordinated with a thematic review of data on the Safeguards, which is discussed in the main body of this report. The purpose of the thematic review is to equip inspectors with more information and, in particular, to provide comparative information on use of the safeguards. The thematic review should therefore help an inspector to appraise whether a service or area is significantly high or low in the applications made to supervisory bodies and the notifications that we have received.

These steps should ensure that all inspectors can access better information than before, and have the ability to interpret it and follow it up as appropriate. We discuss later in this report, how we intend to build on it and monitor how it translates into checks 'on the ground'.

How we monitored supervisory bodies in 2010/11

The NHS Health and Social Care Information Centre (IC) regularly collects a range of information from local authorities and primary care trusts in their roles as supervisory bodies for deprivations of liberty. In our first report on the Safeguards, we noted large variations in the IC's data on use of The Safeguards between areas. We were able to use the performance assessment process for local authorities and primary care trusts to obtain some explanation for these variations.

However, now that our predecessor regulators' roles have ceased, CQC has no function of assessing the performance of commissioners. Both primary care trusts and local authorities have been in a situation of uncertainty over the last year, which has made it difficult for us to develop any other means of obtaining information beyond the IC's data set:

- Local authorities are in the process of developing a new system of collaborative review which will, in effect, replace the old system of performance assessment. This is still in development and our efforts have gone into contributing to its planning and ensuring coordination, rather than developing separate information flows.
- PCTs are in the process of winding down and transferring their role in authorising the Safeguards to local authorities, to take effect from 1 April 2013. They have little spare capacity for additional data requests, and the different speeds and approach to change in different parts of the country could make analysing information difficult.

Appendix 2: Developments in case law

Deprivation of liberty is broadly defined by Article 5 (1) of the European Convention on Human Rights. However, there is no single detailed definition or checklist that can be used to assess whether a person is being deprived of their liberty. Each situation has to be assessed on its own merits and each person's individual capacities and circumstances taken into account.

In 2008, the government published a Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. Both codes have statutory force. Paragraph 2.3 of the 2008 Code states that:

"The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from 'restraint' or 'restriction' to a deprivation of 'liberty'. Where an individual is on this scale will depend on the concrete circumstances of the individual and this may change over time."[8]

There have been several related cases in the European Court of Human Rights and in the UK. Their judgments have helped to refine what deprivation of liberty means. The list below includes the kinds of circumstances that have contributed to judgements that a person is being deprived of their liberty:

- The person is restrained in order to admit them to the hospital or care home,, and restraint would be used to keep them there if necessary
- Medicines given against the person's will
- Staff have complete control over the person's care or movements for a long period
- Staff take all decisions about the person, including choices about care options, treatment and visitors
- Staff refuse to discharge the person into the care of others
- Staff control or refuse the person's access to their friends or family.

Selected recent legal rulings

The responsibility of the supervisory body to apply the Safeguards in the interests of the person

London Borough of Hillingdon v Steven Neary, 27/05/11

Steven Neary had autism and a severe learning disability. At his father's request, he went in to a residential facility for a short period. However, the local authority kept Steven at the facility for a year, against the repeatedly expressed wishes of his father, including a period where he has subject to a Deprivation of Liberty Safeguards regime.

The judge found that the local authority had acted unlawfully in a number of areas and also identified a number of practice issues for those working in the field.

Purpose – the Safeguards are an important safeguard against arbitrary detention. They are designed to protect vulnerable people, not used as an instrument of confinement as was shown in this case.

Decision-making – where a local authority has a number of roles, it should be clear who takes overall responsibility for its direction. This case was characterised by either an absence of decision-making or a disorganised situation where nobody was truly in charge. It was consequently possible for no-one to take responsibility.

Responsibility of the supervisory body – the body must scrutinise the assessment it receives with independence and a degree of care that is appropriate for the case. Here, the supervisory body granted authorisation on the scrutiny of superficial best interests assessments.

Factors to be taken into account in deciding whether there has been a deprivation of liberty

P & Q case, Court of Appeal, 28/02/11

P and Q -v- Surrey County Council [2011] EWCA Civ 190, which was also known as the "Mig & Meg" case, is very significant and was the first time the Court of Appeal considered when a deprivation of liberty may have occurred. It involved two sisters with severe learning difficulties who had as children, been placed in local authority care. Upon reaching adulthood, they were placed by Surrey County Council in two different types of placement - P in a residential college and Q, who was more able, in a specialist home for adolescents. Surrey County Council took the view that these placements did not in either case, amount to a deprivation of the sisters' liberty, despite the fact that constraints were placed upon their movements. For example, both were always accompanied when they left their home, both were taken to and from their places of education, and neither was permitted to cross the road on her own.

Despite it being obvious to all, and agreed between all parties, that the girls were happy in their respective placements and that the arrangements that had been made were in their best interests, the Court nevertheless had to determine whether, objectively, there had been a deprivation of their liberty. Despite the clear restrictions on what they were allowed to do, however, it found that neither sister was being deprived of her liberty. In doing so the court set out a useful checklist of relevant criteria to be applied when deciding whether people in similar situations might be deprived of their liberty :

1. They did not object to being in their respective homes, meaning neither ever attempted to leave; this in turn meant that no restraint was ever required.

2. They had their own bedrooms, allowing some autonomy.

3. They were not under close confinement within the accommodation.

4. They were regularly taken out of the place they lived.

5. They maintained contact with family members.

The court also noted that it would always be relevant to consider a person's capabilities, when deciding if they are deprived of their liberty - "What may be a deprivation of liberty for one person may not be for another."

Cheshire West and Chester Council v P & M, 14/06/11

In Cheshire West and Chester Council -v- P [2011] EWCA Civ 1257, the Court of Appeal again considered the meaning of deprivation of liberty. This case involved a young man (P) with severe learning and physical disabilities and challenging behaviour, who was placed by the council in a supported living environment. The regime he was subject to was more restrictive than in "Mig & Meg", because it was sometimes necessary for P to be dressed in a bodysuit that restricted his movement, and because his behaviour, which included aggressive outbursts, sometimes needed to be controlled through physical intervention amounting to restraint. P was "completely under the control of members of staff" at the house he lived in. Nevertheless, the Court found there was no deprivation of his liberty, because P could not be compared to a man of his age without his diabilities. "Because of his disabilities, P is inherently restricted in the kind of life he can lead." The court found that P would have been subject to similar restrictions wherever he was living, and that these were necessitated by his need for intensive support and assistance. They found the case to be very different to the Bournewood Case (which demonstrated the need for the DOL safeguards in the first place) because there was nowhere else for P to go that would be less restrictive of his freedom.

RK v BCC and others, 30/11/11

This case concerned a disabled child accommodated in a care home by the local authority. It showed the factors taken into account when deciding if someone accommodated under section 20 of the Children Act 1989 with the consent of their parents is considered deprived of their liberty.

The judge ruled that parents are able to authorise restrictions on their child's liberty provided it does not result in detention and that the 'normal' care package designed to protect the child from harming themselves or others does not amount to detention.

The case did not indicate that that any child in this situation will be automatically exempt from a deprivation of liberty.

The approach to be taken by eligibility assessors

GJ v The Foundation Trust, 02/11/09

A 65-year old man suffered from dementia and other mental health issues as well as diabetes and hypoglycemic attacks.

The judge decided the man could not be detained under the Safeguards authorisation for the treatment of his mental disorder, but he could be to receive care and treatment for his physical disorder (diabetes). As such, he was eligible to be deprived of his liberty.

The judge carried out a careful analysis of the statutory provisions for DoLS and the Mental Health Act and set out questions to guide the eligibility assessor through the task of deciding whether the Safeguards can be used.

The decision maker must focus on the reason P should be deprived of liberty by asking:

a) What care and treatment should P have while in hospital:

- For his physical disorders or illnesses that are unconnected to and unlikely to affect his mental disorders, and
- For (i) his mental disorders, and (ii) his physical disorders or illnesses that are connected to them and/or which are likely to directly affect his mental disorders.

b) If the need for the physical treatment did not exist, would he conclude that P should be deprived of liberty in a hospital?

And then on that basis:

c) Whether the only effective reason why P should be deprived of liberty in hospital is the need for the physical treatment.

If (b) is answered in the negative and (c) in the affirmative, then P is eligible for DoLS.

In this case P had two clear and separate health problems, a mental disorder and insulin dependent diabetes. The judge concluded the reason for the deprivation was the treatment for diabetes. P was therefore eligible for the Safeguard

References

[1] The Care Quality Commission (Registration) Regulations 2009, regulation 18. Available at http://www.legislation.gov.uk/uksi/2009/3112/introduction/made

[2] The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments -Amendment) Regulations 2009. Available at http://www.legislation.gov.uk/ukdsi/2009/9780111474242/contents

[3] MOJ (2008) *Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice* London: TSO. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

[4] Optional Protocol to the United Nations Convention Against Torture and Other Cruel, Degrading or Inhuman Treatment or Punishment. Details of the UK National Preventive Mechanism are available at http://www.justice.gov.uk/about/hmi-prisons/preventive-mechanism.htm

[5] MOJ (2008) *Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice* London: TSO. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

[6] MOJ (2008) *Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice* London: TSO. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

[7] Available at http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

[8] Code of Practice to the Safeguards, referenced above, page 17