Deprivation of Liberty Safeguards

Annual Monitoring Report for Health and Social Care

1 April 2011 - 31 March 2012

AGGCC CSSIW
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Care and Social Services Inspectorate Wales

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DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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Foreword

Any one of us might temporarily or permanently lack the mental capacity to make decisions about how we wish to be cared for, whether as a consequence of a sudden injury, a degenerative condition or a life-long impairment. The Deprivation of Liberty Safeguards have now been in place for over three years. All managers, clinicians and staff working in social care and health services must know and understand the Safeguards even if they have not yet used them. While the number of people to whom the Safeguards have been applied remains small, the potential number of people with impaired mental capacity whose well-being and welfare requires robust and well-informed decision making is much larger.

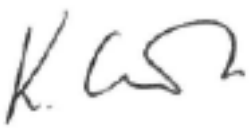
Overall, more Deprivations of Liberty were authorised this year than in previous years. Despite this, two supervisory bodies received no applications and our monitoring has highlighted that the safeguards are still applied inconsistently. In part this may variation reflect the diverse services within which the Safeguards can apply, but we are concerned that knowledge and understanding of these important Safeguards is not yet embedded in everyday practice.

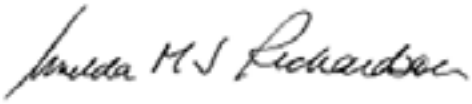
This report raises key issues. It reminds supervisory bodies and managing authorities to ensure that they understand their responsibilities and check how far they are able to answer some of the questions and challenges raised. They should also compare themselves with other supervisory bodies to develop their understanding of why differences might arise.

It is clear that more can be done to inform individuals and their families of their rights and we encourage supervisory bodies to give this continued priority.

We hope that this report is of interest to individuals and their families who are or could be in need of social care and health services as well as to those responsible for making decisions about and providing care to people who cannot make their own choices.

In the coming year, we will extend our monitoring so that we gather more qualitative information and further explore the key elements of good practice. We will do this with stakeholders, including care home residents and hospital in-patients who have had direct experience of the Safeguards, to determine how improvements can be achieved.





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Executive Summary

Background

This is the third annual report setting out the way that the Deprivation of Liberty Safeguards (the Safeguards) have been used across Wales. It combines the findings arising from the inspection work of Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW), and draws on information gathered from local authorities and health boards (supervisory bodies).

The Safeguards were put in place as an addendum to the Mental Capacity Act (The Act), which sets out a rights-based framework to support people who may have problems in making decisions about their health, welfare or finance. They provide a legal framework for the necessary deprivation of liberty ensuring breaches of the European Convention on Human Rights are prevented. The Act requires that individuals are assumed to have mental capacity unless assessed otherwise and reinforces their impaired capacity in one area of life does not prevent an individual from monitoring decisions in other areas. Deciding whether an individual is having their liberty restricted in a way that the Mental Capacity Act allows, or whether they are being deprived of their liberty calls for clear understanding of an individual's circumstances and careful judgement.

The Safeguards:

- aim to empower and protect any individual (the relevant person) with mental disorder and, where there is doubt about their mental capacity, to make informed decisions about their care when they are hospital patients or residents in a care home;
- deal with situations where someone may need to be deprived of their liberty in order for them to receive the care they require and ensure that such loss of freedom is lawfully authorised;
- require care or treatment to be undertaken in the least restrictive way compatible with preventing harm, while being in the relevant person's best interests;
- place specific responsibilities on social care and health organisations.

The threshold between restricting someone's liberty and depriving them of their liberty is not defined and continues to be debated. The Code of Practice requires that each case be judged on its merit.

From the information available to us we are unable to categorically state that all deprivations of liberty have been recognised or that they have resulted in an application or authorisation under the safeguards. The fact that no applications were made to some supervisory bodies during the year and the very low levels of applications made to some other health boards and local authorities suggest that deprivations may have occurred but were not recognised as such under the

legislation. We are concerned that when deprivations of liberty are not recognised or acknowledged, the Safeguards are not applied and hence individual human rights are not protected.

We have analysed this year's information and made comparisons with the previous two years where appropriate. In summary, we found that:

- The total numbers of applications made to supervisory bodies was 545. (10 of these were still in progress at the year's end.) Managing authorities in social care made 383 applications (70% of the total) affecting 292 individuals. Managing authorities in health made 162 applications (30% of the total), these related to 136 individuals. Some individuals were subject to consideration by both health and social care supervisory bodies.
- Provisions within the Safeguards which allow the relevant person, family members and others to exercise rights and gain access to support have not been used frequently. The total number of standard authorisations granted by supervisory bodies was 298. Local authority supervisory bodies granted 72% of the total (216) and health board supervisory bodies granted 28% (82). The number of standard authorisations granted overall was higher than in the two previous years. In hospitals, just over half of the applications for authorisation to deprive a relevant person of their liberty were agreed; in care homes the proportion was slightly higher at 56%.
- Reviews of the qualifying requirements for an authorised deprivation of liberty were held infrequently. Over the last three years, the number of reviews has varied, with 30 held in 2011-12, 22 in 2010-11, and 65 in 2009-10. Despite this there have been some indications of better practice for example; Denbighshire County Council reviewed one person three times within the period of authorised deprivation in 2011-12. Managing authorities in social care granted themselves fewer urgent authorisations compared with the previous years, while health care managing authorities granted themselves more.
- More relevant persons and relevant persons' representatives have received support from Independent Mental Capacity Advocates (IMCAs), although the numbers are still low. Overall, the percentage of managing authorities in health and social care using the Safeguards has continued to rise slowly from a low baseline.
- The highest proportion of applications granted was for men aged 85 years and over, while women aged 65 years and over had their liberty deprived more often than men. There are marked differences between the number of authorisations granted by individual supervisory bodies. Numbers range from 0-35.8 per 100,000 population across local authorities and individual health board authorisation rates vary between 0-10.3 per 100,000 population. In some areas the low number of applications being authorised has coincided with a reduction in the number of applications being made in the following year.

- In health settings more applications were made for men aged between 18 and 84 years than women of the same age. This is also true of the previous year. There is no evidence of over-representation by ethnic minorities.

Conclusions and next steps

The Safeguards are not being used consistently across Wales. This year has seen the highest number of standard authorisations being granted since the Safeguards were put in place. It is evident that some individual local authority and health board supervisory bodies have established effective models for the receipt, assessment and authorisation of applications. However, this year for the first time two supervisory bodies received no applications.

Where no or few applications were made, awareness raising and staff training on both the Mental Capacity Act and the Safeguards needs to be extended. All supervisory bodies need to ensure that their decisions about authorisations are transparent and provide feedback to the applying managing authority in a way that does not discourage future applications.

The infrequent use of reviews of qualifying requirements gives rise to concern. The data gathered offers no explanation and this needs to be further explored by supervisory bodies as part of their own quality assurance arrangements.

Undoubtedly there are managing authorities who work hard to care for people with impaired capacity without depriving them of their liberty. However, there will be occasions when a managing authority has no alternative but to lawfully deprive people of their liberty in order to give them the care they need. We have taken account of the direct individual experience of relevant persons through discussion with inspectors and reviewers. However, despite the valuable insight individual experience brings, it does not support robust conclusions about the general effectiveness of the Safeguards.

We are concerned that there is no clear indication of what level of utilisation of the Safeguards equals good practice. Quantative data has allowed us to draw some broad conclusions, but we need more qualitative data to make clearer judgements about the effectiveness of the Safeguards in promoting better outcomes for the relevant person. In the coming year, HIW and CSSIW will explore this further with stakeholders.

We plan to undertake further work to provide a more complete picture. We will refine our data collection incrementally, with small changes being introduced in March 2013. We will introduce further improvements after consultations with stakeholders. We will also undertake further inspection fieldwork in health and social care settings to examine, and the rest of Deprivation of Liberty Safeguards Practices.

Chapter 1: The Safeguards

The Deprivation of Liberty Safeguards (the Safeguards) were implemented on 1 April, 2009 to ensure that individual human rights are upheld. They apply to individuals, (known as the relevant person) of 18 years and over with a mental disorder who lack mental capacity to give informed consent to the arrangements made for their care, if they either live in a care home or are patients on a hospital ward. The Inspectorates' monitoring role relates to the application of the Safeguards in Welsh hospitals and care homes. If the Court of Protection authorises any deprivations of liberty in any other setting, for example supported accommodation, they fall outside of the remit of Healthcare Inspectorate Wales (HIW) and CSSIW.

Welsh Ministers have a duty to monitor the operation of the Safeguards in Wales, which Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW) undertake on their behalf.

The Safeguards are accompanied by a Code of Practice[1] which sets out:

- the process for making an application for the authorisation of a deprivation of liberty;
- details of how an application for authorisation should be assessed;
- the requirements that must be fulfilled for an authorisation to be given;
- the process for reviewing an authorisation;
- details of the support and representation that must be provided to individuals who are subject to an authorisation;
- the way in people can challenge authorisations.
- a detailed explanation of the Safeguards is provided at Appendix B.

As in the two previous years, supervisory bodies were asked to submit information on every application they received under the Safeguards. Where the information indicated possible practice issues; these were followed up with the managing authorities or supervisory bodies by the relevant Inspectorate to confirm the validity of the data or to understand the circumstances that led to the particular decision or concern.

When the safeguards were first introduced in April 2009 we agreed that as part of our monitoring role we would ask managing authorities and supervisory bodies the same questions for a minimum of three years. Having now collected and analysed three years work of information we are now in a position to undertake some revision to these. We have not formally collected information from supervisory bodies about applications to the Court of Protection, although we are aware that a small number of cases have been heard relating to Welsh care home residents or hospital patients. We intend to ask for this information retrospectively for the year 2012-13, so that further qualitative data can be analysed.

[1] Deprivation of Liberty Safeguards Code of Practice. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Two supervisory bodies located in different areas of Wales, Gwynedd Council and Hywel Dda Health Board received no applications under the safeguards. (Appendix B shows the location of the seven health boards and the 22 local authorities which act as supervisory bodies in Wales). However, in the same geographical area as Gwynedd Council, Betsi Cadwaladr University Health Board received applications from managing authorities of hospital wards. In the Hywel Dda Health Board area where health managing authorities did not use the power, managing authorities in care homes made applications to all three local authorities. Managing authorities that never use the Safeguards or do so infrequently will struggle to ensure that staff and managers maintain the necessary expertise. If they fail to recognise when a patient or care home resident is potentially being deprived of their liberty, they are not meeting statutory requirements.

The threshold between restricting someone's liberty and depriving them of their liberty continues to be debated. The Code of Practice requires that each case be judged on its merit. In hospitals, just over half of the applications for authorisation to restrict the relevant person's liberty were agreed. In care homes the proportion was slightly higher at 56%. Nonetheless, whether authorised or not, those care homes and hospitals that made applications under the safeguards ensuring that the relevant person's circumstances were examined independently. We are concerned that where potential deprivations of liberty are not recognised or acknowledged, the Safeguards are not being applied and hence on individuals human rights are not being protected.

Chapter 2: The individual and ensuring their rights are respected

The Code of Practice to the Safeguards sets out requirements that ensure that an individual is properly represented, has a voice at the time an application to deprive them of their liberty is made and if granted, continues to be heard during the lifetime of the authorisation. As stated earlier the Safeguards are a specialist area of the Mental Capacity Act 2005.

The Act sets out five key principles:

- We must begin by assuming that people have capacity;
- People must be helped to make decisions if they need help;
- Unwise decisions do not necessarily mean lack of capacity;
- Decisions must be taken in the person's best interests;
- Decisions must be the least restrictive of freedom as is possible.

Staff working in health and social care should be aware of these principles and know how to follow them in everyday circumstances. They are essential to providing citizen centred care and should be embedded in working practices. However, findings from inspections and reviews undertaken by both Inspectorates indicate that widespread understanding of the Mental Capacity Act cannot be assumed. We as the inspectorates have a key role in monitoring the impact of the Safeguards on residents of care homes and patients on hospital wards and highlighting the relevance of the Act including the Safeguards in these settings.

In social care, care home managers are the "managing authority" whether they are run by local councils or by independent organisations. There were 1159 care homes registered to admit adults in Wales at the end of March 2012. This compares with 2010-11 when the number was 1169, and 2009 -10 when it was 1186. CSSIW aims to visit each home at least once during the year. Some care homes will have been visited more often, especially where concerns have been raised. Where any resident is subject to an authorised deprivation of their liberty at the time of the inspection, inspectors are required to follow up their outcomes with the registered manager or the senior person on duty.

In the preparation for this report we reviewed a sample of care home inspection reports published by CSSIW during the year. Where references were made to the Safeguards, the sample showed that inspectors commented on training of staff, availability and quality of care home policies and whether care plans clearly detailed the manner in which the individual's authorised deprivation of liberty should be managed. (This is particularly important to avoid inconsistencies between the rights limited by the authorisation and those limited in practice by care home staff.) Reports within the sample indicated that these aspects

needed further improvement, although some examples of good practice were noted. However, inspectors did not explicitly refer to the Safeguards in all cases. CSSIW has embarked on a modernisation agenda which includes re-focussing its reporting format and inspection arrangements. Early indications suggest that through the enhanced focus on reporting on people's experience of using regulated services, issues relating to restrictions of liberty have become more apparent. The importance of monitoring the implementation of the Safeguards by inspectors through inspection visits has been recognised and will be built upon.

In health care, senior staff managing in-patient beds in hospitals are the managing authority. At the end of March 2012 Wales had approximately 130 NHS hospitals[2] with 11,781 inpatient beds[3]. A further 42 independent acute or mental health hospitals and hospices are registered with HIW.

A range of inspection and review activities are undertaken in these settings, which will look at the circumstances of the care given to individuals who lack capacity, as well as exploring with staff their understanding of and training on the Mental Capacity Act and the Safeguards. In particular, visits are undertaken to mental health wards to monitor the use of the Mental Health Act. Where concerns regarding an individual who appears to be subject to the deprivation of their liberty and also appears to lack capacity to agree to them are indentified, these are escalated to senior managers within the organisation and followed up in writing to seek assurances that the matters have been addressed either through the Mental Health Act, Mental Capacity Act or by changing the way the individual receives care.

Who has been affected by the Safeguards?

The process involved 136 individuals in health care settings and 292 in social care were subject to the safeguards. Some people were subject to the Safeguards more than once during the year, of whom a number were protected in both a hospital and a care home setting. (It is not possible to quantify these numbers because supervisory bodies in health and social care use different identifiers.) No ethnic minorities are over-represented, with 99% of applications concerning individuals whose ethnic origin is reported to be white.

[2] NHS Hospital Directory - http://www.wales.nhs.uk/ourservices/directory/Hospitals
[3] Health Statistics Wales 2012

Chart 1: Number of applications to local authorities and number of identifiable individuals involved

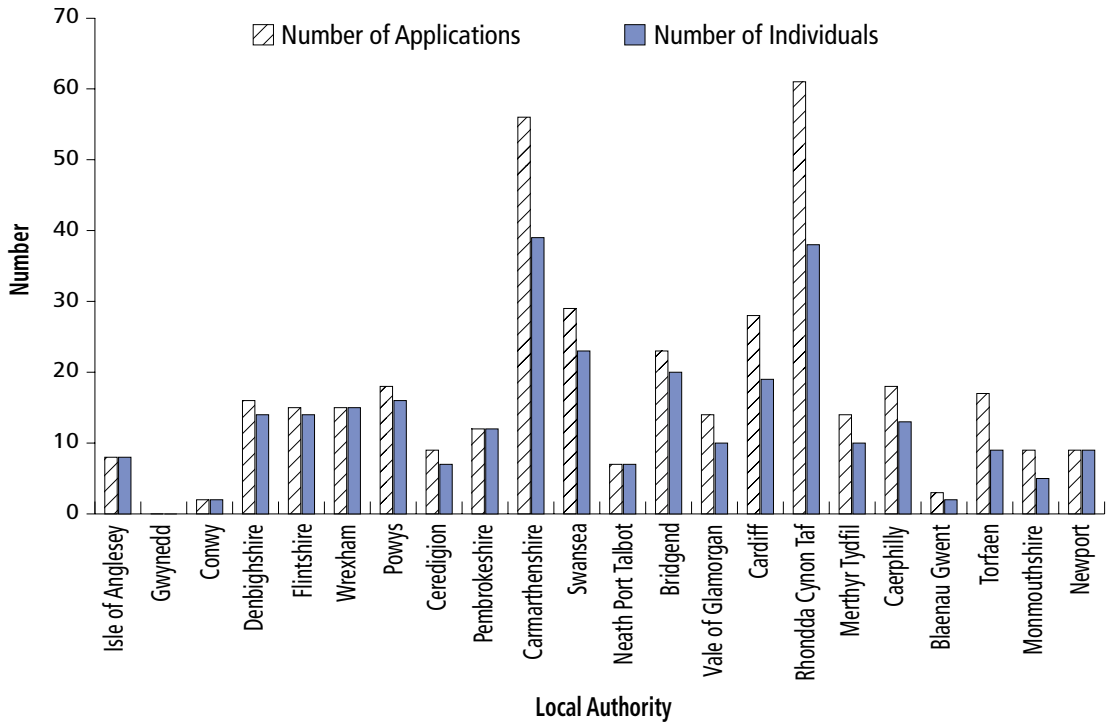
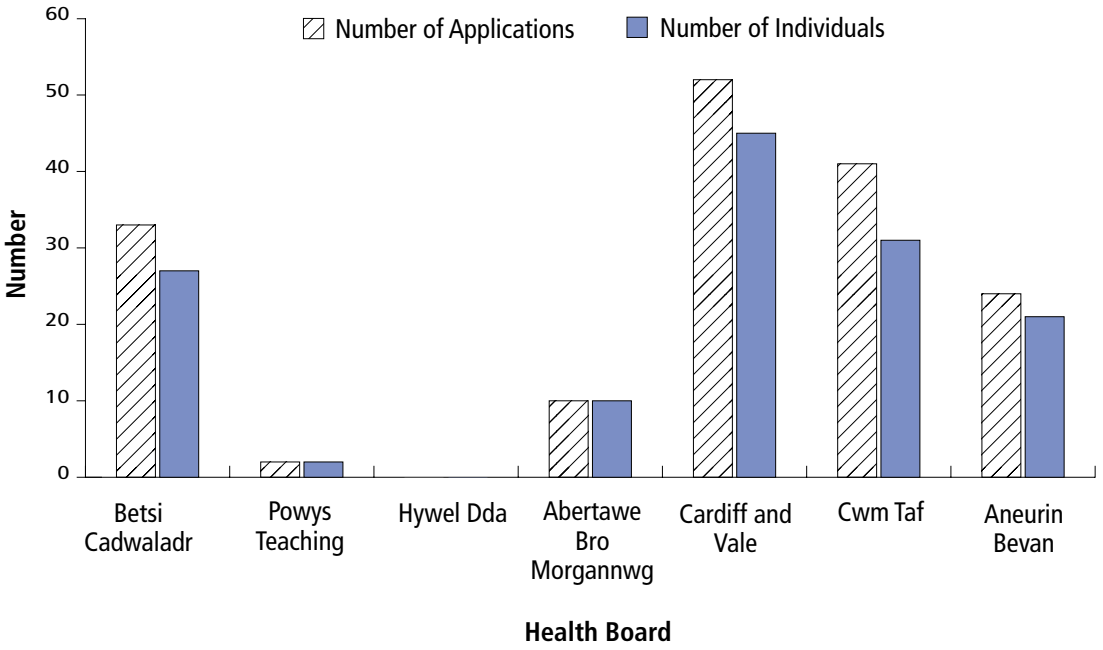


Chart 2: Number of applications to health boards and number of identifiable individuals involved



In total 545 applications were made under the Safeguards in 2011-12. This resulted in the granting of 298 standard authorisations. However, 261 urgent authorisations had already been put in place by the managing authority at the same time as an application for a standard authorisation was made. All applications made to supervisory bodies for authorised deprivations of liberty go through a process of assessment against six separate criteria. This process is described more fully in Appendix C. More applications were made than authorised because the assessment criteria was not met in some cases. Some applications and authorisations were made in relation to the same relevant person.

Table 1: Authorisations put in place in Wales 2011-12

	Urgent Authorisations	Standard Authorisations
Health	110	82
Social Care	151	216
Wales	261	298

41% of all applications made were for women resident in care homes. Nearly half of all applications made concerning women were for those aged 85 or older.

Chart 3: Age and gender of individuals-all applications in 2011-12

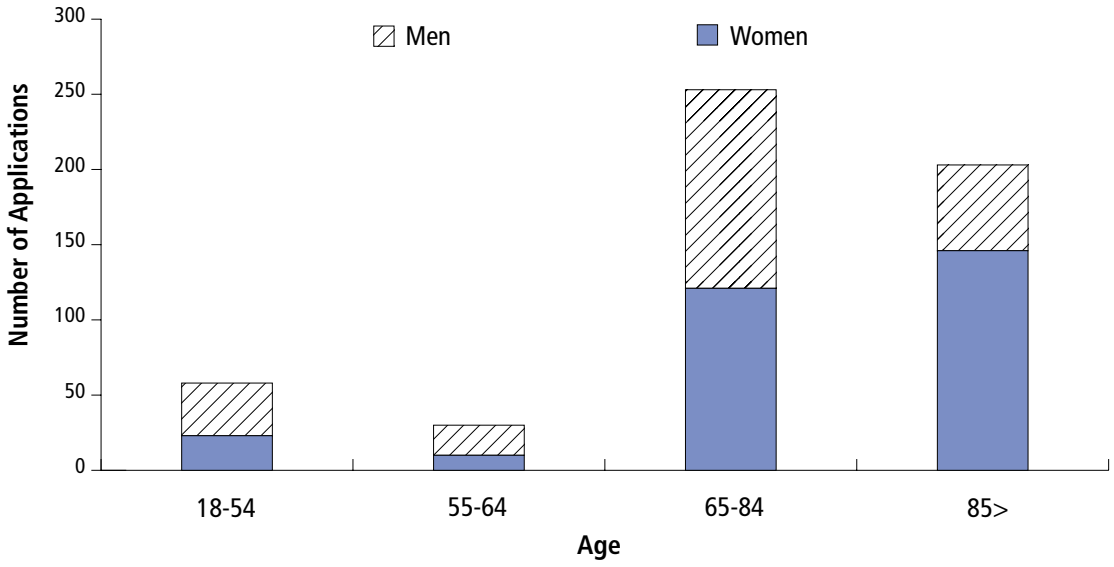
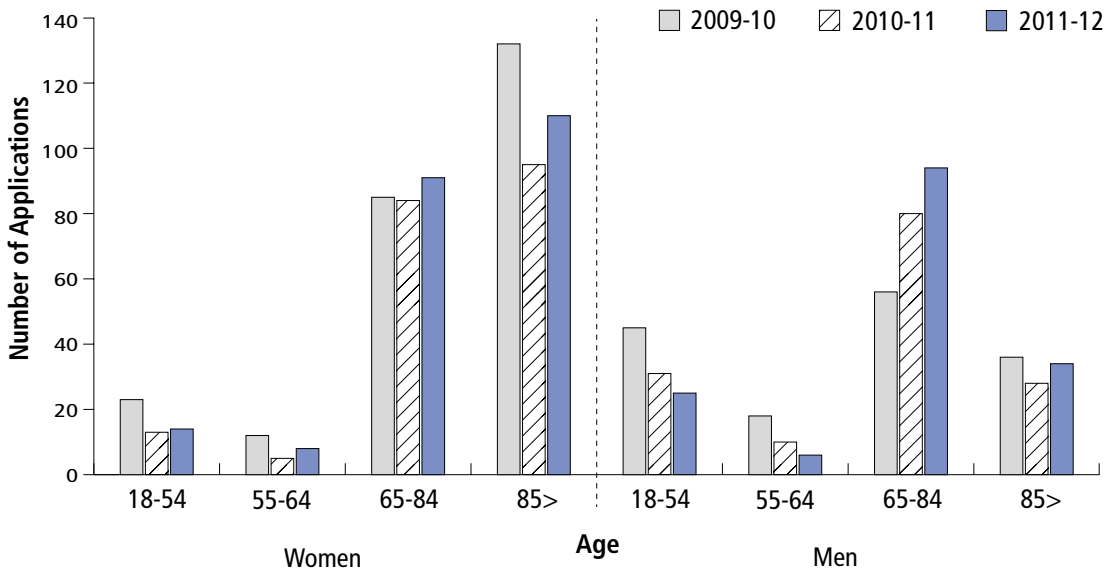


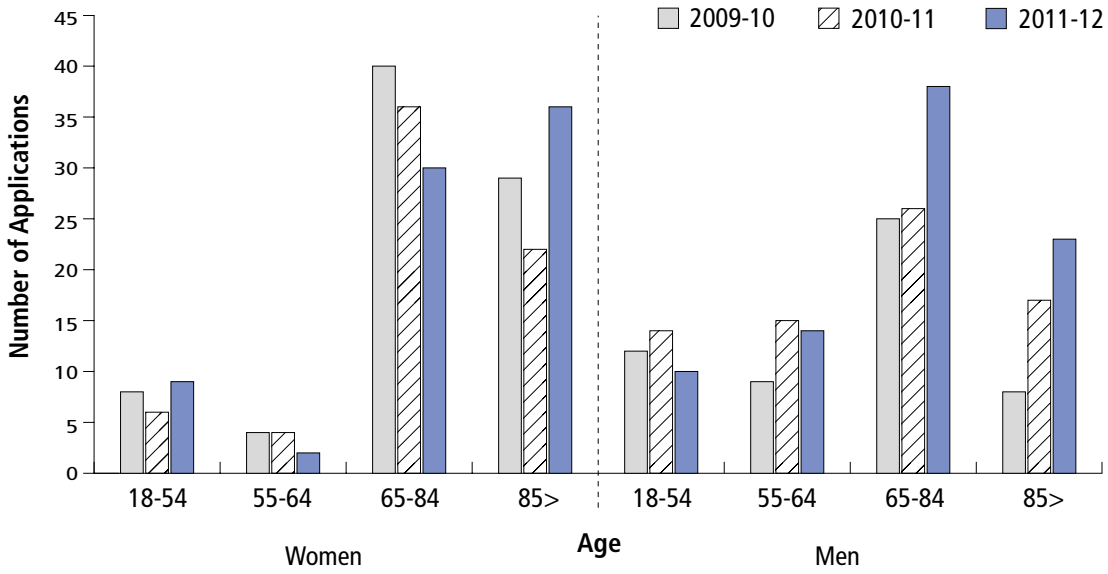
Chart 4 shows the age and gender of individuals whose circumstances triggered applications from care homes over the last three years. It shows broadly similar patterns for women, although the numbers of women affected was higher in the first year. There is more variation for men with a noticeable increase in the proportion of men aged 65-84 years subjected to the safeguards in 2011-12.

Chart 4: Age and gender of individuals-all applications in social care



In hospitals slightly more men (53%) were the subject of applications this year although the proportion of younger men has decreased. The majority of men and women were aged 65 or older. Chart 5 shows the distribution over the past three years.

Chart 5: Age and gender of individuals-all applications in health



How do relevant people have their rights upheld?

Supervisory bodies and managing authorities are responsible for ensuring that relevant persons and their representatives are informed of the implications of the Safeguards, are aware of their rights and supported to act on them. Individual and family circumstances are often complex which makes decision making difficult. Key provisions within the Safeguards for highlighting and challenging decisions have been used infrequently over the three years that the safeguards have been in place. There is a continuing need for supervisory bodies and managing authorities to inform the relevant person, their family, friends and carers of their rights, which in turn means that responsible managers and staff must also be aware of them.

Other protective aspects of the Safeguards are:

The Best Interests Assessor

Best Interests Assessors are responsible for seeking the views of a range of people interested in the welfare of the relevant person, including the person themselves, their family and friends. The Best Interests Assessor determines whether the relevant person is being deprived of their liberty and if so, whether this is in their best interests. It is vital that each Best Interests Assessor is able to undertake this role effectively. This requires adequate initial training and regular up-dating to incorporate new information such as judgements published by the Court of Protection. They need to gain and maintain experience through completing sufficient assessments. It is a challenge for supervisory bodies where no applications have been received to ensure that they can maintain access to skilled and experienced Best Interests Assessors.

Third Party Requests

Relatives, friends, advocates and anyone concerned about the relevant person and the manner in which they are being cared may approach the appropriate supervisory body to request that it gives consideration to whether the Safeguards need to be applied. This is known as a third party request. Only seven third party requests were made this year, one of which was made by a relative. The most usual category of referrer is "other professional". Over the last three years, the number of third party referrals made in any year has never been higher than nine. This suggests that this right is not well known or understood.

The Relevant Person's Representative

When an authorisation is granted, the supervisory body must appoint a relevant person's representative, who is independent of the hospital or care home, to maintain contact with the relevant person. This representative could be a family member or friend although in certain circumstances it may be more appropriate

for a suitable independent professional to be appointed. The appointed person has a duty to maintain contact and support the individual in all matters concerning the Safeguards. The selected representative does not have to agree with the deprivation of liberty and the appointment can be changed to another suitable person during the lifetime of an authorisation. The managing authority is responsible for recording whether the relevant person's representative visits regularly. They should highlight any concerns about a relevant person's representative to the responsible supervisory body so they can exercise their duty to monitor the effectiveness of the representative.

Table 2: Types of people appointed as relevant person's representatives

	Carer/Relative/Friend	Other
Local Authority	158	58
Health Board	60	22
Total	218	80

The majority of relevant person's representatives are relatives, carers or friends. Most relevant person's representatives described as 'other' were noted to be advocates.

In almost all cases, the same relevant person's representative was in place for the duration of the authorisation. While this should make monitoring of their input straightforward and allow analysis, by supervisory bodies, of the quality of support given to the relevant person, we have no information about how supervisory bodies monitor such input. This is an area that we will examine in more detail in future years.

Supervisory bodies should ensure that non-professional relevant person's representatives who have taken on this important role are not financially disadvantaged. There is an option in Wales for supervisory bodies to make a payment to any relevant person's representative for out of pocket expenses[4].

Court of Protection

The Court of Protection offers the relevant person, their representative or other family members a process of appeal in cases of dispute where supervisory bodies have granted standard authorisations in a care home or hospital. Supervisory bodies are expected to seek a judicial decision where they are aware of disagreement with their actions. Judges can set aside decisions made by supervisory bodies, confirm them or make declarations (a court determination

[4] The regulatory framework differs from that in England, where only professional relevant person's representatives can be paid.

about one particular decision). The Court of Protection is also the only body that can consider potential deprivations of liberty in settings other than a hospital or a care home. They do not consider urgent authorisations.

Where judgements have been published they have contributed to the overall understanding of the Safeguards. They have also served to raise issues about other aspects of health and social care management, such as the protection of vulnerable adults, prior to the Safeguards being applied. The Court has, for example, made declarations about an individual's capacity and decided whether the Safeguards were the least restrictive option.

While each case considered by the Court of Protection is unique, there are still lessons for managing authorities and supervisory bodies to learn from the reported cases. It would also be helpful for the general principles that have emerged from Court of Protection decisions to be incorporated into any review of the Deprivation of Liberty Code of Practice.

There is continuing information that legal advice is not easily available to the relevant person or their representative. This may be due to a lack of understanding about the legally aided status of the relevant person and their representative, as well as a shortage of solicitors' firms that offer specialist support for such cases.

Reviews

Reviews are crucial to ensuring that the authorised deprivation of liberty continues to be necessary and justified. The purpose of a review is to assess whether the relevant person still meets the qualifying requirements for being deprived of their liberty; whether the reasons why they do so have changed and whether any conditions attached to the standard authorisation need to be varied. If the relevant person's capacity to make decisions about their care improves, the authorisation to deprive them of their liberty must be reviewed. The relevant person or the relevant person's representative must be aware that they can ask for a review and supervisory bodies must respond to any requests in a timely way. The managing authority should be vigilant for any change in the relevant person's condition and where relevant, ask the supervisory body for a review of the deprivation. Supervisory bodies themselves can initiate a review and should have arrangements in place to receive relevant information arising from reviews triggered through the Unified Assessment process.

Table 3: Number of reviews requested in social care and health, and by whom

		2009-10	2010-11	2011-12
Local Authority	Relevant person	2	2	5
	Relevant person's representative	2	3	1
	Managing authority	19	6	5
	Supervisory body	25	10	18
	Total Local Authority	**48**	**21**	**29**
Health Board	Relevant person	0	0	0
	Relevant person's representative	1	0	0
	Managing authority	10	1	1
	Supervisory body	6	0	0
	Total Health Board	**17**	**1**	**1**

A total of 30 reviews were held this year, with all but one held in social care. The relevant person or their representative asked for six of the reviews, a small but encouraging increase on the previous years. Denbighshire County Council initiated 3 reviews on a relevant person during the year which suggests an appropriate level of diligence. This is the kind of practice that should be expected. However, a much higher number of reviews were requested in the first year with managing authorities requesting nearly as many as the supervisory bodies initiated. It is disappointing that managing authorities in social care only requested five reviews this year.

In health care settings, one review was held this year, this was requested by a health managing authority. This figure shows no improvement on last year, and is significantly lower than in the first year. Although authorisations by health supervisory bodies are generally for a shorter period of time, this does not remove the need for there to be proper oversight of authorisations.

The low rate of reviews compared with the number of authorisations is a cause for concern, despite there being evidence of some individual good practice. Issues raised in some of the cases heard by the Court of Protection demonstrate the importance of the review process. Reviews are an important safeguard playing a key role in ensuring that an authorised deprivation of liberty continues to be the least restrictive option for providing care, and managing authorities and supervisory bodies should improve their practice in this respect. All supervisory bodies must have arrangements in place to ensure that people who are deprived of liberty have their circumstances reviewed at appropriate intervals.

Independent Mental Capacity Advocates (IMCAs)

For a second year we have collected information about the appointment of an IMCA. There are specific situations when IMCAs offer support and guidance:

- The Section 39A IMCA is involved at the outset by a supervisory body whilst an application is being considered for a vulnerable individual with no discernable family or friends (the 'un-befriended'). They must represent the individual to enable their voice to be heard.
- The Section 39C IMCA can take on the role of the relevant person's representative if the original representative ceases to hold that role, until another is appointed.
- The supervisory body can refer the relevant person or their representative to a Section 39D IMCA. This IMCA's responsibility is to advise and inform them, and in particular to make use of the review process or gain access to the Court of Protection.

In most cases (94%) a Section 39A IMCA was not appointed. Overall health boards made 11 appointments, and local authorities made 23. These figures show a very small growth in the use of IMCAs for un-befriended people. Supervisory bodies should monitor trends in the use of IMCAs and assure themselves that un-befriended people are identified and supported appropriately. Last year, no Section 39C IMCA was requested. This year, a health board supervisory body appointed one, and local authorities appointed two. For the remaining 213 authorisations the same relevant person's representative was appointed for the duration of each authorised deprivation, so interim arrangements were not required.

Supervisory bodies appointed a Section 39D IMCA to support the relevant person or their representative in 38 cases, this represents 13% of all authorisations and is nearly double last year's figures. Health supervisory bodies appointed eight, while local authority supervisory bodies appointed 30. This is an encouraging upward trend, introducing improved practice which should be sustained. As we have noted, the majority of relevant person's representatives are family, carers and friends to whom a Section 39D IMCA can offer significant support and help ensure that the voices of individuals deprived of their liberty and their friends and family are properly heard.

Table 4: Number of cases where IMCAs were appointed in social care and health

		2010-11	2011-12
Local Authority	39A IMCA	22	23
	39C IMCA	0	2
	39D IMCA	14	30
Health Board	39A IMCA	9	11
	39C IMCA	0	1
	39D IMCA	6	8

Information on use of IMCAs was not collected in 2009-10

Some relevant persons have been protected by adult protection procedures as well as the Safeguards with the authorisation of a deprivation of liberty occurring as part of a wider protection plan. We are aware also that where the assessment of a deprivation of liberty has revealed that the relevant person's best interests were not being served the procedure to protect vulnerable adults was invoked.

Chapter 3: Applications for Authorisation

Every application for a standard authorisation made by a managing authority triggers the safeguarding assessment process. All assessment criteria has to be satisfied before a deprivation of liberty can be authorised. Managing authorities are able to grant themselves urgent authorisations, if they feel they are already unavoidably depriving someone of their liberty, at the same time as applying to the supervisory body for a standard authorisation. Urgent authorisations are also dealt with in Chapter 4.

Managing authorities made 545 applications for authorisations from supervisory bodies, just two fewer than in the first year. When the Safeguards were being developed it was forecast that there would be around 630 applications in Wales each year and it is still too soon to know where the number of applications will settle.

More care homes (nearly 16%) used the Safeguards this year with supervisory bodies in local authorities receiving 383 applications[5] from 181 care homes. This compares with fewer than 10% in the first year, and nearly 15% in the second year. Our analysis shows that 55 care homes have consistently used the Safeguards over the three years.

In relation to 39% of applications (151 cases) managing authorities in social care had granted themselves an urgent authorisation before applying for a standard authorisation. This figure is lower than preceding years and hopefully indicates better forward planning.

Health boards received 162 applications for patients in 44 hospitals (30% of the total number of applications). In 110 cases (nearly 68%) an urgent authorisation had already been put in place. While urgent authorisations are more likely to occur in health settings as many admissions are unplanned, the Code of Practice guidance advises that:

> *'In the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. There may, however, be some exceptional cases where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered.'*

There were 23 individuals from Wales receiving care in England who were subject to applications; six from hospitals, none of which were granted, and 17 from care homes, with nine granted.

Some care homes are still on occasion finding it difficult to identify the supervisory body, when their residents come from a wide geographical area. Managing authorities making applications for the authorisation of a deprivation of liberty

[5] 10 were still in progress at the end of 2011-12

must apply to supervisory bodies where the relevant person previously lived, not where their care homes are located. The supervisory body is the local authority social services department who arranged the individual's place in the care home, because they were originally resident in their area. In the case of people funding their own care, the local authority in the area in which they were previously resident is the supervisory body.

Some registered managers appear to confuse the protection of vulnerable adults and the Deprivation of Liberty Safeguards processes. Where there is an adult protection concern, the social services area in which the care home is situated should be contacted. However, where the registered manager has concerns that a resident with impaired capacity can only be cared for adequately if deprived of their liberty, they should make an application to the supervisory body, which may be a different local authority.

Rhondda Cynon Taf County Borough Council and Cardiff and Vale University Health Board received the highest numbers of applications No applications were received by Gwynedd Council and Hywel Dda Health Board. The charts below illustrates the number of applications made per 100.000 of the population to highlight the comparison between supervisory bodies.

Chart 6: Applications to local authorities as a proportion per 100,000 population 2011-12

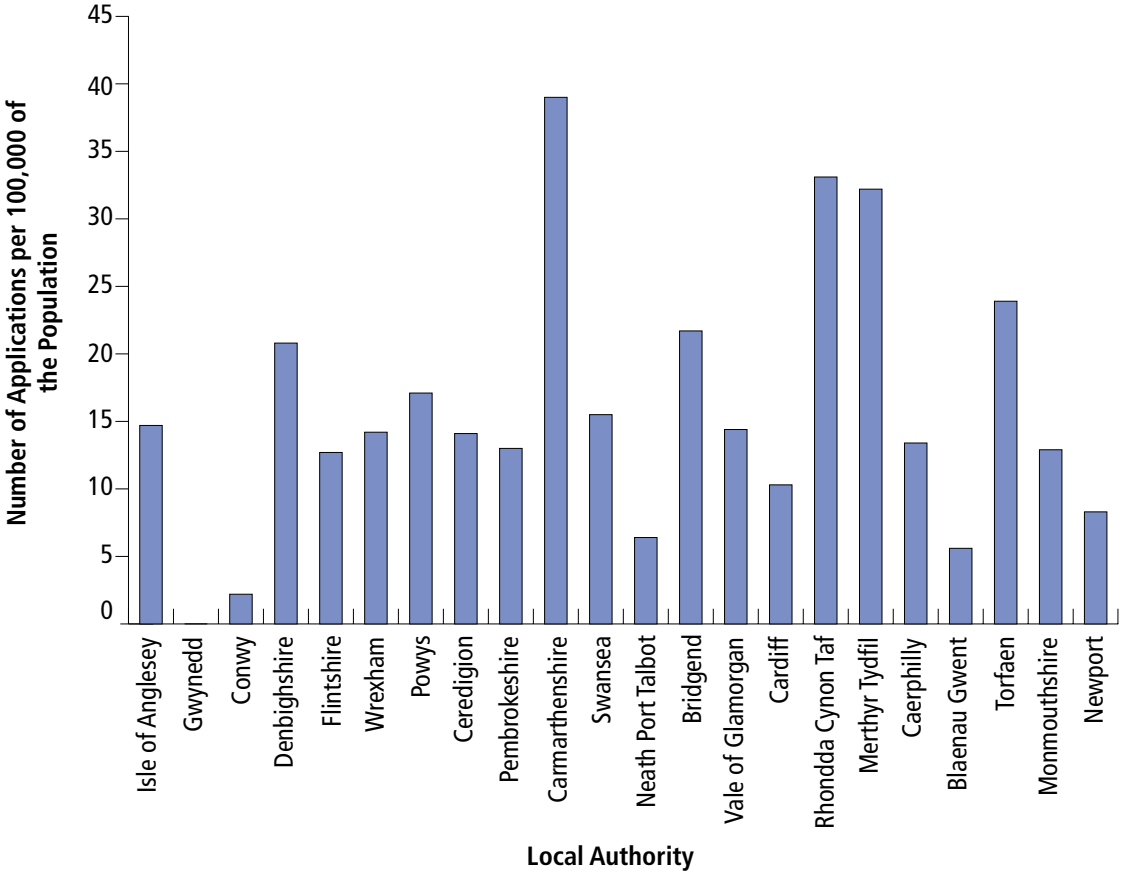
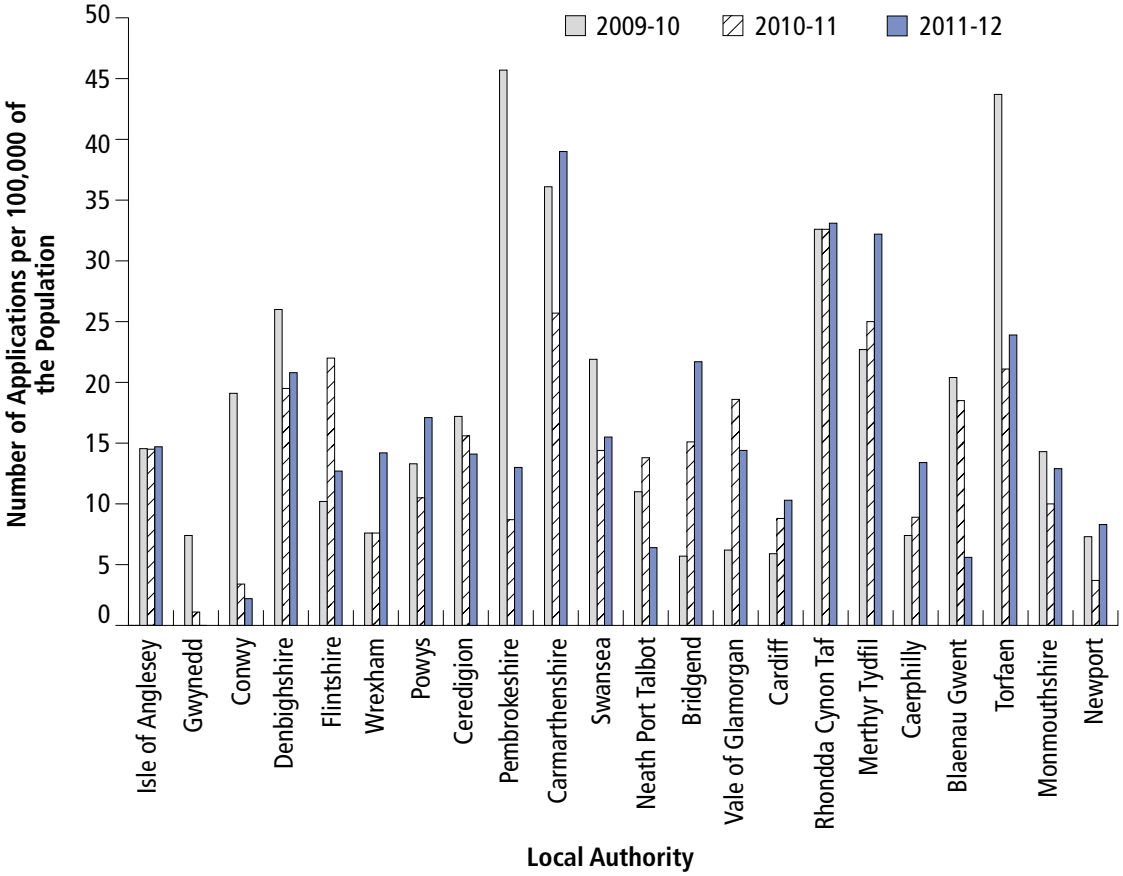


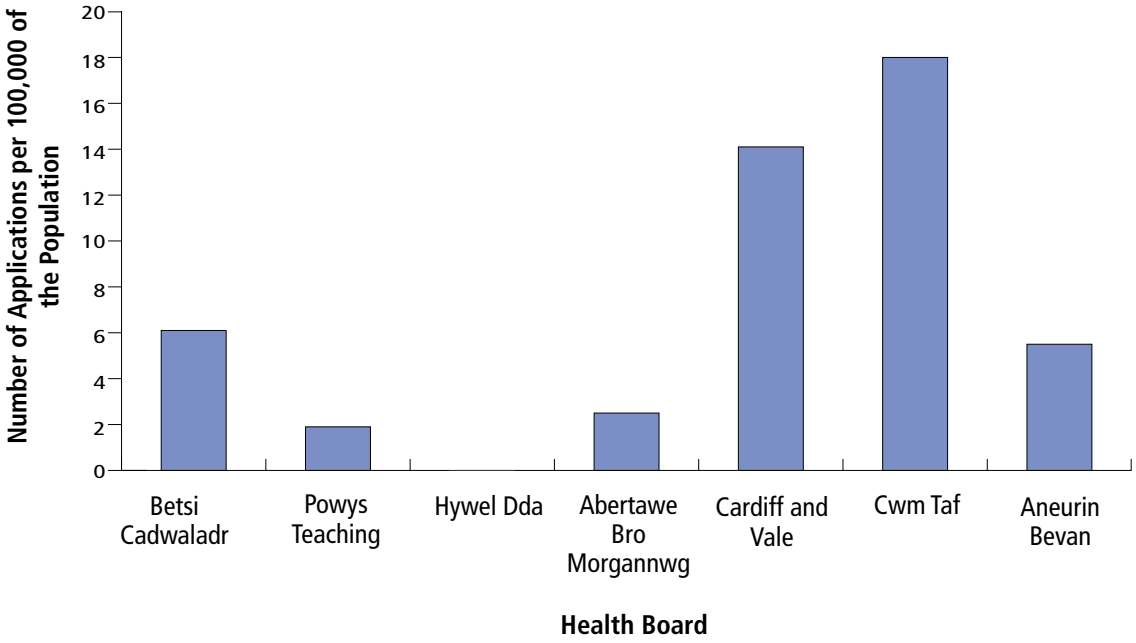
Chart 7 highlights even more clearly the extent of variation in the numbers of applications between each local authority and from year to year. There are local authorities showing consistent returns over three years, for example Rhondda Cynon Taf and Anglesey. Some supervisory bodies have received fewer applications each year, while others have received more with each succeeding year.

Chart 7: Applications to local authorities showing three year trends 2009-2012



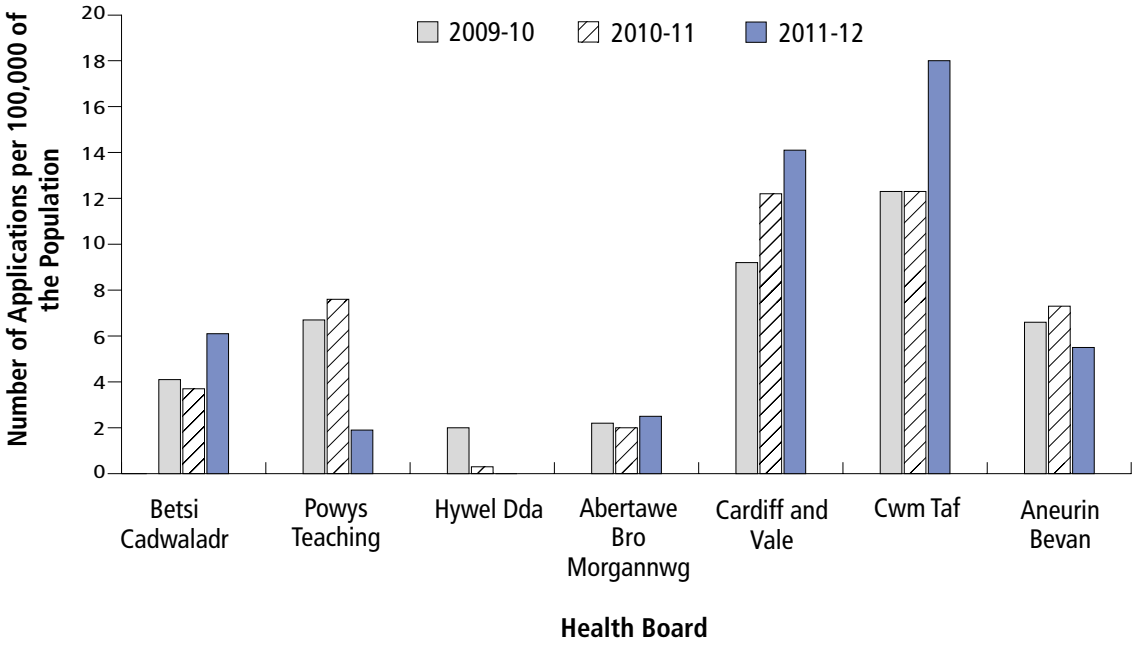
Cwm Taf Health Board received the highest number of applications per 100,000 head of population in 2011-12. The Health Board covers the same geographical area as Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council who also had high numbers of applications per 100,000 head of population. At the other end of the spectrum, Hywel Dda Health Board received no applications from its hospitals, although the three local authorities covering the same area all received applications from care homes. These are Pembrokeshire County Council, Ceredigion County Council and Carmarthenshire County Council.

Chart 8: Applications to health boards as a proportion per 100,000 population



There is some consistency over three years, with Cardiff and the Vale and Cwm Taf Health Boards regularly receiving higher number of applications than other Health Boards.

Chart 9: Applications to health boards showing three year trends 2009-2012



Managing authorities across health and social care need to give careful consideration to why this variability has developed. Overall, the number of requests for authorisation of deprivation of liberty appears to be low, in particular when set against the number of care home and hospital beds specifically offering support to people with conditions known to impair mental capacity. In areas of no or low usage of the safeguards they need to consider whether they and their staff are recognising situations where people are being deprived of their liberty.

Supervisory bodies also have a role in raising awareness of the safeguards through workforce development and commissioning. They need to ensure that they are promoting the knowledge and understanding of the legislation and guidance. There should be clear and constructive feedback to managing authorities regarding unsuccessful applications.

Chapter 4: Authorisations granted

Supervisory bodies only authorise a standard application for a deprivation of liberty when the required assessments of the relevant person have been undertaken and relevant criteria met. There were 298 standard authorisations across Wales in 2011-12. 216 applications were granted by local authority supervisory bodies (72% of all applications), and 82 (28%) by health board supervisory bodies.

The balance between applications where an urgent authorisation is already in place and applications for standard authorisations alone has shifted over three years in social care. In health care, more standard authorisations have been preceded by an urgent authorisation, showing an increase each year.

Table 5: Authorisations put in place in Wales 2009-2012

	Health		Social Care	
	Urgent Authorisations	Standard Authorisations	Urgent Authorisations	Standard Authorisations
2009-10	84	77	249	177
2010-11	88	74	161	203
2011-12	110	82	151	216

The proportion of applications authorised by each supervisory body has varied over the last three years. Both the total number and percentage of applications authorised by local authorities has increased since the first year when more applications were rejected. This suggests that in some local authority areas, managing authorities using the Safeguards are getting better at correctly identifying a deprivation of liberty that is in the best interests of the relevant person. Health board supervisory bodies have granted more than half of the applications made to them each year, although the percentage has reduced in each of last 2 years.

Table 6: Numbers and percentages of applications granted and not granted

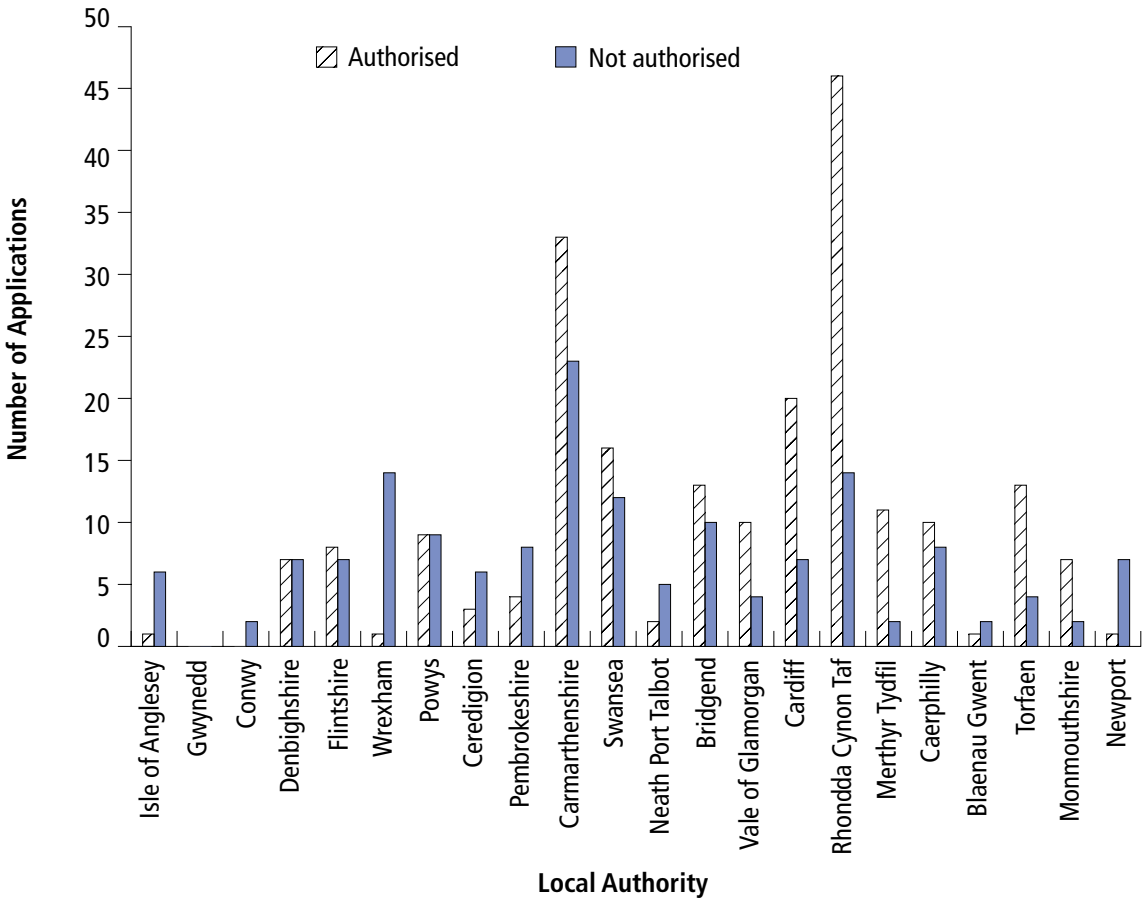
	Local Authority		Health Board	
	Granted	Not granted	Granted	Not granted
Number				
2009-10	177	229	77	58
2010-11	203	141	74	64
2011-12	216	159	82	78

	Local Authority		Health Board	
	Granted	Not granted	Granted	Not granted
Percentage				
2009-10	44	56	57	43
2010-11	59	41	52	45
2011-12	56	42	51	48

NB: Some percentages do not add up to 100% as some cases were still in progress on 31 March 2012

The total number of authorisations does not show the variation in decision making between local authority supervisory bodies. In 2011-12, 11 local authorities have authorised more applications than they rejected. However, eight local authorities have rejected a higher number than they authorised. The local authorities are spread throughout Wales which does not suggest any particular pattern. Some of the local authorities have shared assessment arrangements with health boards, but this has not brought any clusters of authorisations, suggesting that, as is required, each case is considered on its merits.

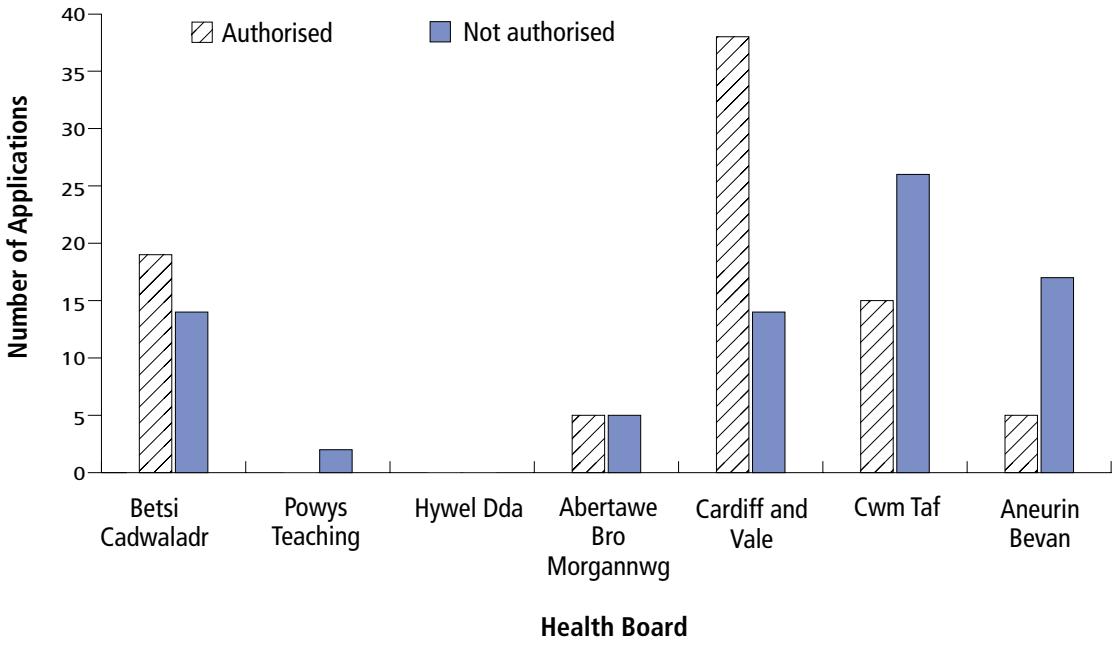
Chart 10: Number of applications authorised and not authorised by local authority supervisory bodies in 2011-12



Two health board supervisory bodies authorised a higher proportion of applications, while one authorised half of its applications. The remaining three health boards who received applications rejected a higher proportion.

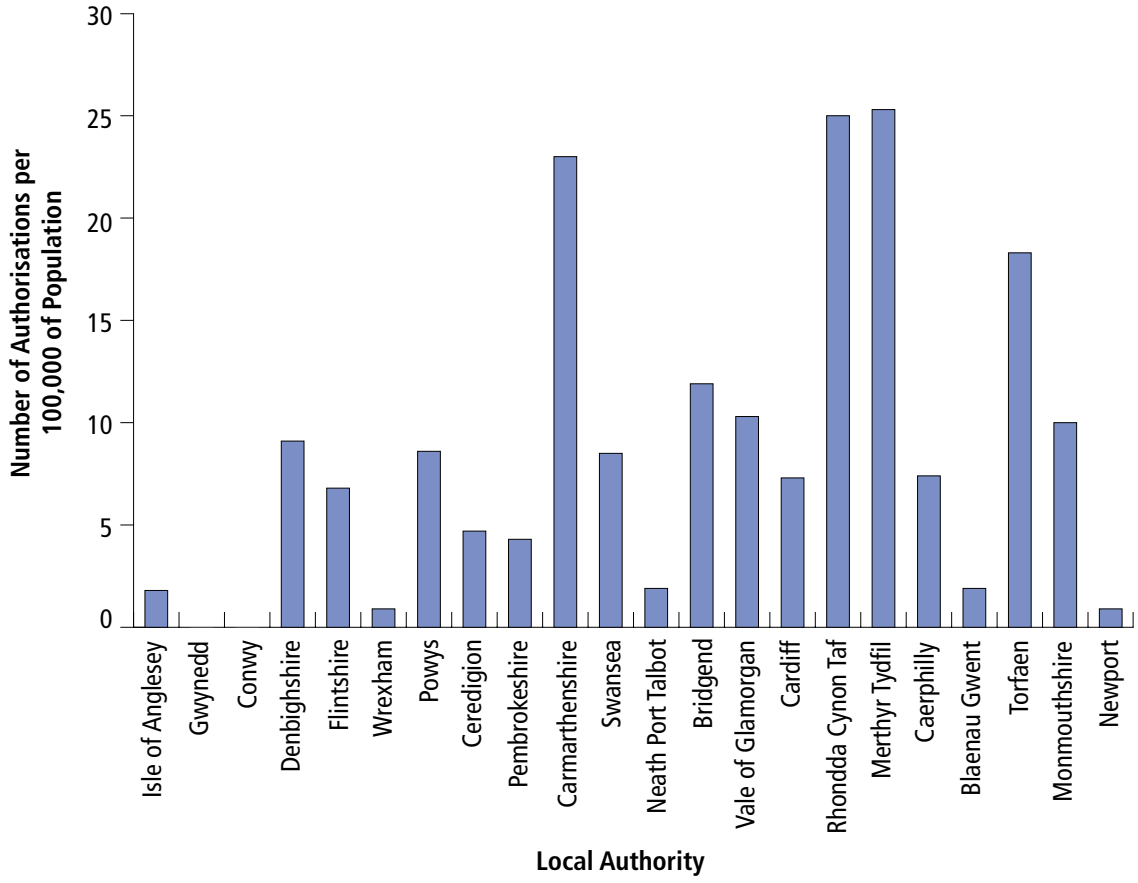
Each local authority and health board serve different sized populations, so the charts below show the outcomes when allowances are made for those differences.

Chart 11: Numbers of applications authorised and not authorised by health board supervisory bodies in 2011-12



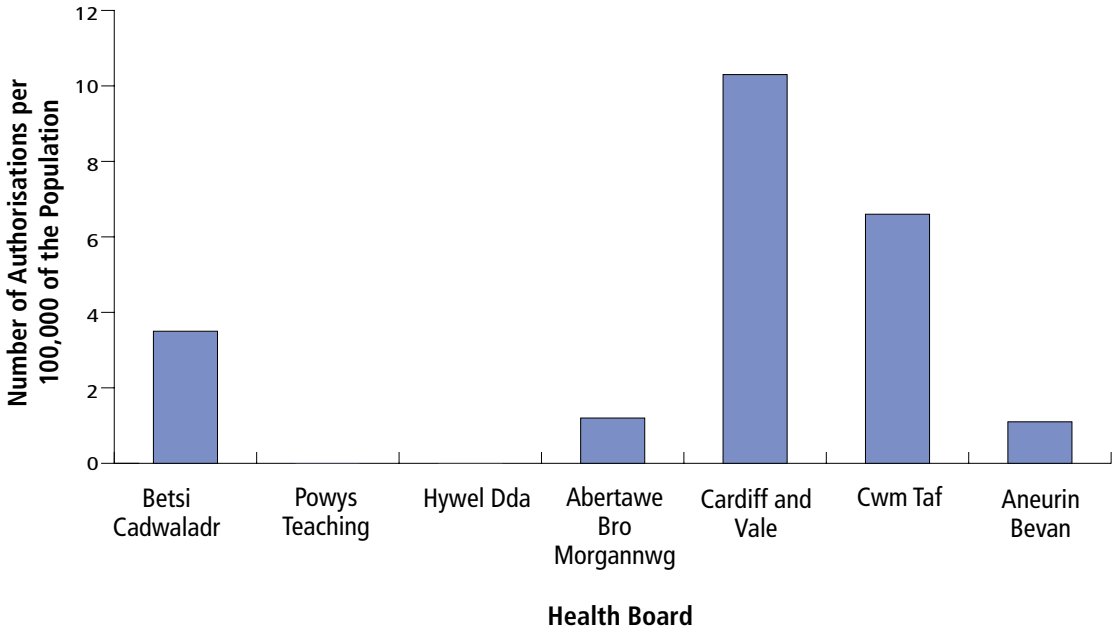
Comparisons between local authorities can more easily be made if the numbers of authorisations are expressed per 100,000 of the population.

Chart 12: Numbers of applications authorised by local authorities as a proportion per 100,000 population



Of all the Welsh Health Boards, Cardiff and Vale University Health Board authorised the highest number of applicants in the year whether considered as an overall number or as a proportion of their population. This is shown in Chart 13.

Chart 13: Numbers of applications authorised by health boards as a proportion per 100,000 population



The health board and local authority supervisory bodies who should be most concerned are those where the Safeguards have not been used, or had consistently low usage over this year and the preceding two years. Where there have been no applications, the supervisory bodies need to consider whether they are doing enough to make the Safeguards known about and available.

Reasons for not granting authorisations

Authorisations were not granted because one or more of the 6 assessments that a supervisory body is required to undertake identified that a condition had not been met. In some cases applications were withdrawn due to changes in the circumstances. Applications were more often withdrawn when the individual was being cared for in a health care setting where the length of stay is shorter.

Table 7: Reasons why authorisations are not granted

	Health Boards	Local Authorities	Wales
	Percentage		
Not a Deprivation	43.6	47.2	46.0
Best Interest	20.5	27.7	25.3

	Health Boards	Local Authorities	Wales
	Percentage		
Mental Capacity	9.0	6.9	7.6
Eligibility	7.7	2.5	4.2
Mental Health	1.3	0.6	0.8
Withdrawn	17.9	14.5	15.6
No refusals	0.0	0.6	0.4

The most common reason for an authorisation not being granted is because the supervisory authority considered the individual to not be deprived of their liberty i.e. "not a deprivation". It is acknowledged by many sources, including the Mental Health Alliance[6] report that correctly identifying a deprivation rather than a restriction of liberty can be problematic. What constitutes a Deprivation of liberty has not been clearly defined in the legislation or the Code of Practice, which states that a deprivation is a matter of "degree or intensity not one of nature of substance". Managing authorities have to ensure that they keep the relevant person's needs and circumstances under review. This is important as incremental changes in care practices may alter the relevant persons circumstances from one that is a restriction of liberty to one that is a deprivation of liberty. Where applications are not accepted, the supervisory bodies need to feedback to managing authorities the reasons why and support them to correctly identify deprivations of liberty.

Timescales for assessment

The required timescales for assessment are set out in legislation and regulation and it is important that they are met. Where a managing authority has put an urgent authorisation in place, the maximum time allowed for assessment is 14 days. Of the 261 applications following on from an urgent authorisation, 13 took more than 15 days to complete. Three of these took more than 28 days.

Table 8: Time between application and decision

	Local Authority		Health Board	
	Standard	Standard following urgent	Standard	Standard following urgent
Same day	10	2	2	0
1-7 days	52	99	28	90
8-14 days	62	38	9	13
15-28 days	88	6	12	4
Over 28 days	16	2	1	1

[6] Mental Health Alliance "The Mental Health Act 2007: a review of its implementation" May 2012, including chapter 2 on the Deprivation of Liberty Safeguards

In health care a decision was reached in 14 days or less in 89% for standard authorisations that followed urgent authorisations. In social care, compliance was achieved in only 70% of cases. Improvements are needed wherever poor compliance in responding to urgent authorisations occurred, as it is important that people are not deprived of their liberty for a longer period than necessary.

Table 9: Supervisory bodies that did not meet the required timescales for assessments

	Number of days taken for completion of assessments
Anurin Bevan Health Board	96
Merthyr Tydfil Local Authority	33
Rhondda Cynon Taf Local Authority	31
Merthyr Tydfil Local Authority	28
Cwm Taf Health Board	27
Neath Port Talbot Local Authority	21
Denbighshire Local Authority	20
Cwm Taf Health Board	19
Cwm Taf Health Board	17
Cardiff and Vale Health Board	15
Neath Port Talbot Local Authority	15
Swansea Local Authority	15
Carmarthenshire Local Authority	15

The timescales are calculated differently for applications for standard authorisations. In Wales, standard authorisations should be completed within 21 days[7] once the assessors have been instructed. The chart above illustrates the variance in compliance to timescales, the reasons for such delays are not presently reported.

Supervisory bodies must monitor the time taken to complete assessments and improve performance where required, ensuring that the necessary resources are in place to do so. All supervisory bodies failing to meet legislative and regulatory requirements are accountable for any unlawful detentions that occurred during that time. Court of Protection judgements have commented on the undue delay in the completing of assessments and the Court is likely to take a close interest where this has been a factor in future cases.

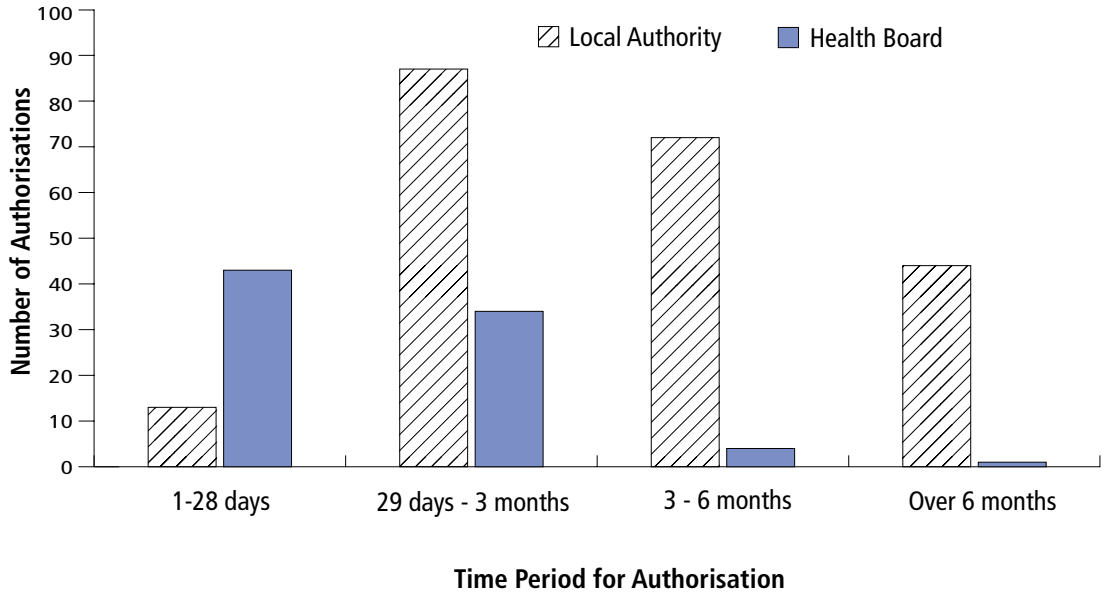
[7] The regulatory position differs in Wales from England, where time limits for completing standard authorisations are measured from the point when an application is received.

Length of authorisations

Once granted, an authorisation has an expiry date which cannot be extended. An authorisation cannot last more than 12 calendar months. If the individual's circumstances still warrant the deprivation of their liberty at the point when an authorisation expires, a new application has to be made and the circumstances re-examined.

Only one health board granted an authorisation for longer than six months and most (94%) authorisations in health were valid for less than three months. This can be explained by the short term nature of most hospital stays. In social care where care homes often provide a home for an extended period, a number of authorisations (30) were for the full 12 months period. However in most Best Interests Assessors recommended a period of six months or less, this appears to be in recognition of the fact that an individual's circumstances and care needs can change substantially in a 12 month period.

Chart 14: Time period for which authorisations were valid in 2011-12



Lengths of time that individuals were actually subject to an authorisation

Whereas the majority of authorisations granted by local authority supervisory bodies ran for the full period of 12 months, after the first year the majority in health care settings did not. This is explained by the short term nature of a hospital stay.

Table 10: Numbers of authorisation that ran for their full period of validity

	Local Authority		Health Board	
	Ran for the Full Period	Did not run for the Full Period	Ran for the Full Period	Did not run for the Full Period
2009-10	64	21	48	24
2010-11	78	35	26	42
2011-12	95	53	33	42

These are authorisations that ended by 31st March.

Whatever conditions and timescales for authorisation are set supervisory bodies should monitor the managing authorities' compliance.

Conditions imposed on authorisations

Conditions can be placed on any authorisation and most of those granted during 2011-12 included conditions which focussed on the individual needs of the relevant person. Local authority supervisory bodies were less likely to impose conditions, nearly 30% of authorisations having no conditions, while health board supervisory bodies imposed conditions in 80% of cases. Supervisory bodies who did not apply conditions to authorisations need to examine whether this achieves the best outcome for the relevant person.

Authorisations reflect individual circumstances and are granted for different reasons. The overall intention is to keep people safe and allow them to receive care and support even if they do not want to be in a hospital or a care home. However, some themes have developed. Some local authorities were more likely to use the Safeguards to restrict access by relatives where there are concerns about their intentions towards the relevant person. Where this is the case and the individual moves to hospital without an authorised deprivation of liberty, care must be taken to communicate clearly with the health care provider areas of possible risk.

Case example-Importance of using the Safeguards to protect a relevant person who moves between a care home and hospital

A relevant person, who was subject to an authorisation in a care home, went to hospital for treatment. No authorisation for a deprivation of liberty was considered necessary in hospital. A family member visited and appeared to behave oppressively towards the relevant person. A member of the public visiting another patient reported their concerns. Action was then taken to protect the relevant person.

Conditions applied to authorisations in social care settings

'A multi-disciplinary agreement to consider the stimuli to be introduced to the relevant person and timeframes for this to be incorporated into his behaviour management plan. This must include the commissioners of his service.'

'The physical intervention plan for relevant person to be reviewed every four weeks.'

'An activity plan to be devised for relevant person to ensure she is engaged in meaningful thing to do and therefore less likely to wander and attempt to leave the home.'

'Assist with visits from daughter.'

'Robust record keeping of the timing of the incidents from start of behaviour to its conclusion.'

'Relevant person to be encouraged to go out with carers or on trips.'

'Relevant person's representative to be consulted regarding all care.'

Conditions applied in healthcare settings

'Arrange transfer to rehabilitation hospital as soon as possible.'

'Facilitate transport for home visits with family.'

'If relevant person is un-willing to engage in (developing) self-care skills, further attempts to encourage will be made through the period of continuing stay in hospital.'

'Staff to find time to sit and talk with relevant person to enable her to communicate her frustrations at the loss of her independence and her fears.'

'Accompany off ward for periods of time.'

'Patient's daughter as relevant person's representative to be offered support by ward staff in this role.'

Some of the conditions suggest that the arrangements for the relevant person were not fully set out in their personal plan of care. The last example given above could also have made clear whether support from a Section 39D IMCA had been offered. Conditions are used as a way of ensuring care staff understand and follow both the processes of the Safeguards and other requirements of the Mental Capacity Act.

Chapter 5: Organisational arrangements to support compliance with the Safeguards

The configuration of the supervisory bodies has remained relatively stable. Local authority supervisory bodies have retained the same arrangements for the past three years, and the health board configurations have been in place for over two years. These arrangements indicate that there should be a consistent pattern of decision making.

However, some local authorities and health boards have created joint team arrangements which have been in place since the implementation of the Safeguards. They are:

- Aneurin Bevan Health Board, Blaenau Gwent County Borough Council, Caerphilly County Borough Council, Monmouthshire County Council, Newport City Council and Torfaen County Borough Council;
- Cardiff and the Vale Health Board, Cardiff City Council and The Vale County Borough Council;
- Cwm Taf Health Board, Merthyr Tydfil County Borough Council and Rhondda Cynon Taf.

Other local authorities and health boards act on their own behalf although several come together for practice discussion and training. These arrangements are in place between the Betsi Cadwaladr health board and the six local authorities in North Wales, and Powys Health Board and Powys County Council also work closely together.

The distribution and range of care provided by managing authorities is diverse, from small family-run care homes to hospitals with thousands of in-patients. All managing authorities are responsible for knowing how their own residents and patients are being cared for regardless of size and organisational capacity. Managers and staff must understand the Mental Capacity Act and the Safeguards and be able to identify when they should be used and how to make applications, as a recent Court of Protection judgement[8] made very clear

The links between the number of care homes in a local authority area and the number of applications it receives as a supervisory body are not straightforward. Rhondda Cynon Taf County Borough Council granted more authorisations than any other local authority supervisory body and has 64 registered care homes within its boundaries. Conwy did not grant any authorisations but nevertheless has a higher number of care homes than its neighbouring areas.

There is more correlation in health board areas. The Cardiff and Vale University Health Board is the largest provider of NHS beds and as managing authority made the highest number of applications, the majority of which were authorised.

[8] G v E, Manchester City Council and F (2010) EWHC 2042 (Fam.)

Evidence from inspections of care homes and hospitals continues to demonstrate that understanding of the Safeguards varies. There are competent practitioners who promote the rights of the individual. However, even where an authorisation has been made, some continued questions about the welfare of individuals can arise.

Case example

CSSIW inspectors in south east Wales became aware of an individual who had been subject to an authorised deprivation of liberty in a care home where there were concerns about low standards of care. When the relevant person was moved to another care home, he thrived and it was not necessary to deprive him of his liberty. Had this individual's circumstances been regularly reviewed it is possible that there would have been much earlier consideration of whether it had been in the best interests of the relevant person to be made to stay in the first home. In Chapter 11, the Code of Practice makes it clear that monitoring of the process by Inspectorates will not constitute an alternative review or appeal process. Nevertheless, this experience has been drawn to the attention of the commissioning local authority so that they can consider whether there are any lessons to be learned.

In the previous two reports, we highlighted the position in Wales where Best Interests Assessors do not have to complete an accredited training course. The situation has not changed, although supervisory bodies continue to seek a solution with Welsh academic bodies. Some supervisory bodies have commissioned training from accredited courses in England to ensure that their Best Interests Assessors are well equipped for the role. Judgements from the Court of Protection leave no doubt that the relevant person must receive proficient and timely assessment. Supervisory bodies are responsible for ensuring that quality assurance mechanisms are in place and that assessors working on their behalf are competent.

Separation of managing authority and supervisory body roles

In Wales health boards and local authorities hold both the supervisory body and managing authority roles in different parts of their organisations and there has to be clarity about and separation of these respective responsibilities. The Code of Practice and Welsh Government Guidance clearly set out the need for separation of duties to avoid any potential conflict of interest. We have highlighted good practice in this respect in previous years.

Understanding of the Mental Capacity Act

We remain concerned that the wider Mental Capacity Act continues to be poorly understood by staff providing direct care in health and social care. CSSIW inspectors continue to come across care workers who do not recognise that residents may lack capacity to make some decisions, but can still make everyday choices. The provision of support to assist communication and improve understanding as required by the Act can also be lacking.

Chapter 6: Conclusions, recommendations and next steps

This year has seen the highest number of standard authorisations granted since the Safeguards were put in place. At the same time two supervisory bodies received no applications indicating that there were areas where the Safeguards were not used at all. There are managing authorities that are undoubtedly working hard to care for people with impaired capacity without depriving them of their liberty. There are other managing authorities with no alternative but to lawfully deprive people of their liberty in order to give them the care they need.

Where deprivations of liberty are not recognised or acknowledged, the Safeguards cannot be applied and individuals human rights are not protected. Even where there is evidence that an organisation has used the Safeguards well to provide a protective function for people with impaired mental capacity, more robust evidence of outcomes is needed.

The Safeguards have not been used consistently across Wales over three years, and we are going to look at this in more depth over the coming year. Organisations that sit at either end of the continuum, rejecting or granting more applications than average need to review the practice in the respective areas. The lack of applications in one health board and one local authority this year follows on from low numbers received and authorised in those organisations in the two previous years. Consistency in the application of the safeguards is not in itself an indicator of good outcomes and our evaluation suggests that other aspects of performance warrant our attention.

Supervisory bodies have to be very clear with managing authorities why applications for authorisation have been refused and should encourage rather than discourage applications. Where few applications have been received, awareness raising and training for staff on both the Mental Capacity Act and the Safeguards needs to be extended. All supervisory bodies must have processes in place to evidence transparent decision making accompanied by constructive feedback mechanisms.

The infrequent use of reviews of qualifying requirements gives rise to concern. Reviews have become less frequent after the three years since the introduction of the safeguard despite us having raised this as a concern in earlier reports. This needs to be further explored by supervisory bodies as part of their own quality assurance processes.

The current Code of Practice has been in place for over three years and with three years of data now available a review would be timely. This would also allow any general principles from Court of Protection judgements to be incorporated into practice guidance.

Next Steps

We need better quality information to be clear whether the level of use of the Safeguards indicates good practice. We have analysed information gathered over three years from supervisory bodies and received feedback on the performance of managing authorities from our own inspectors and reviewers.Quantative data has allowed us to draw some broad conclusions, but we need more qualitative data before we are able to make clearer judgements about the effectiveness of the Safeguards in promoting better outcomes for the relevant person. We have taken account of direct individual experiences through discussion with inspectors and reviewers. However, despite the valuable insight individual experience brings, it does not support robust conclusions about the general effectiveness of the Safeguards.

CSSIW and HIW will undertake further work during 2013-14 to enable a more complete national picture of the extent and quality of the implementation of the legislation. We will talk to stakeholders and refine our data collection incrementally with some changes being introduced in March 2013. Further improvements may be indentified following inspection fieldwork in health and social care settings that we plan to undertake during 2013-14. This will put us in a better position in future years to judge performance and evaluate the quality of practice in the application of the Deprivation of Liberty Safeguards.

Appendix A

Key terms used in the Annual Report

The table below is a list of key terms used in this report. Where necessary it may expand on particularly important tasks carried out by significant people.

(This glossary is already translated into Welsh apart from the text in purple and bold, eg Court of Protection.)

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments must be positive for an authorisation to be granted.
• Age	An assessment of whether the relevant person has reached age 18.
• Best interests assessment	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests Assessor.
• Eligibility assessment	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
• Mental capacity assessment	An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.
• Mental health assessment	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.

• No refusals assessment	An assessment of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.
Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
CSSIW	Care and Social Services Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor.
Consent	Agreeing to a course of action-specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

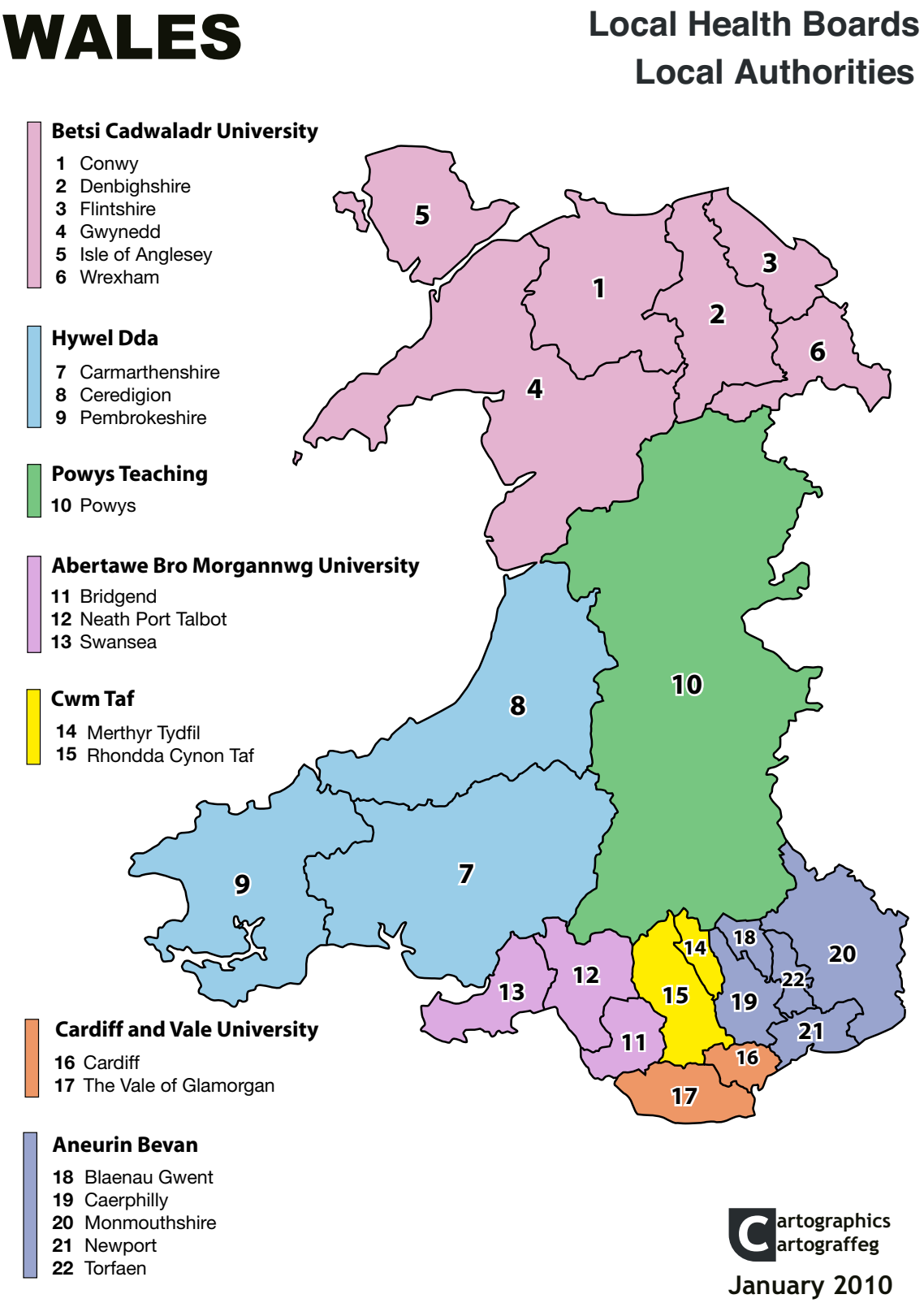
Court of Protection	The specialist court for all issues relating to people who lack **mental capacity to make specific decisions. It is the ultimate decision maker with the same rights, privileges, powers and authority as the High Court. It can establish case law which gives examples of how the law should be put into practice.**
Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
Health Board	Health Boards fulfil the supervisory body function for health care services and work alongside partner local authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being. **They separately manage NHS hospitals and in-patient beds, when they are managing authorities.**
Independent Hospital	As defined by the Care Standards Act 2000 - a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.

Local Authority	The local council responsible for **commissioning** social care services in any particular area of the country. Senior managers in social services fulfil the supervisory body function for social care services. **Care homes run by the Council with have designated managing authorities.**
Managing authority	The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the Best Interests Assessor, and it may end sooner with the agreement of the supervisory body.
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for mental health treatment, supervised community treatment and guardianship.
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.

Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.
Supervisory body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a supervisory body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

Appendix B

Map of Wales showing the locations of supervisory bodies and managing authorities



Appendix C

Further details on the Safeguards[9]

While on a hospital ward or in a care home a patient or resident (called the relevant person in the legislation) with impaired mental capacity and a mental disorder may need to be deprived of their liberty in order to receive the care and treatment they require. Staff have to ask themselves whether they are keeping the person under complete and effective control and denying their requests to leave. They will also need to consider whether this is the least restrictive way of caring effectively for the relevant person.

Deciding whether the relevant person is having their liberty restricted in a way that the Mental Capacity Act allows or whether they are being deprived of their liberty calls for clear understanding of an individual's circumstances and careful judgement. There is guidance such as that provided by the Social Care Institute for Excellence (Scie), which confirms that the Mental Capacity Act allows restrictions and restraints to be used if they are in the best interests of a person who lacks capacity to make the decision themselves, and gives examples of such restrictions. "Restrictions or restraint can take away a person's freedom and so deprive them of their liberty. This may happen if restraint is used frequently or for extended periods, or a number of different restrictions are in place. It is difficult to be clear then the use of restrictions and restraint crosses the line to depriving a person of their liberty."[10]

The Safeguards aim to provide a clear legal framework to ensure that deprivation only occurs in ways which promote the relevant person's best interests.
The circumstances of each case will be unique to each individual, The Safeguards require a set of six assessments to be undertaken and the requirements of each assessment have to be met before a deprivation of liberty can be authorised. Unauthorised deprivations of liberty are unlawful.

When might the Safeguards be used in a hospital?

Some years ago, Mr J had a bad accident and suffered serious head injuries, which have left him with problems with his memory and understanding. He is in hospital having investigations to identify the cause of a number of physical symptoms he has experienced but his brain injury can cause him to become agitated and confused. He has tried to leave the ward and staff have brought him back for his own safety. He also becomes agitated and difficult when staff try to perform the necessary medical tests.

[9] Much of this text appeared in the Annual report for 2010-2011. It is replicated here to give additional information to the reader.

[10]

The healthcare team are considering how best to care for him in order to complete the investigations that he needs and have discussed the possibility of restraining him either physically or by using sedation. Mr J also gets very upset when his family visits and this triggers some of his attempts to leave. Staff think that it may be better for him if they only allow the family to visit once a week.

Mr J's care team are therefore considering whether it is appropriate to request an assessment under the Safeguards to ensure that they have the proper authority to implement their decisions.

When might the Safeguards be used in a care home?

Mrs B has been diagnosed with dementia. She lives at home with her increasingly frail husband who has been providing most of her care, although they also receive home care. The social worker suggests respite care in a nearby care home. However, Mrs B cannot be persuaded to go and look at the care home. When her husband is admitted to hospital as an emergency, Mrs B has to be admitted to the care home immediately by her daughter. Very quickly she becomes agitated, and tries to leave. Her family all agree that she must stay there to give their father chance to recover. An application is made for a standard authorisation, so that she can be cared for legally while her husband is not able to care for her. The care home manager has to carefully consider whether they are already depriving Mrs. B of her liberty; if so an urgent authorisation may be put in place.

The Deprivation of Liberty Safeguards Code of Practice says:

"As soon as the supervisory body has confirmed that the requests for a standard authorisation should be pursued, it must obtain the relevant assessments to ascertain whether the qualifying requirements of the deprivation of liberty safeguards are met. The supervisory body has a legal responsibility to select assessors who are both suitable and eligible. Assessments must be completed within 21 days for a standard deprivation of liberty authorisation, or, where an urgent authorisation has been given, before the urgent authorisation expires." (paragraph 4.1)

The six assessments are:

- age assessment (paragraphs 4.23 and 4.24 of the Code of Practice)
- no refusals assessment (paragraphs 4.25 to 4.28)
- mental capacity assessment (paragraphs 4.29 to 4.32)
- mental health assessment (paragraphs 4.33 to 4.39)
- eligibility assessment (paragraphs 4.40 to 4.57); and
- best interests assessment (paragraphs 4.58 to 4.76).

These assessments may be completed by any two assessors with relevant qualifications, as long as the Mental Health assessment is provided by a different assessor to the Best Interests' assessor. The Code of Practice sets out the process of assessment, who can assess, the timescales for assessment and the duties of supervisory bodies.

There are some circumstances where detention or guardianship under the Mental Health Act 1983 could be more appropriate and this must be considered. Guardianship under section 7 of the Mental Health Act alone may not give sufficient authority to care for someone with impaired mental capacity in a care home, if the appropriate care deprives them of their liberty.

Appendix D

The wider roles of Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate (CSSIW)

Health Care Inspectorate Wales

HIW is the independent inspectorate and regulator of all health care in Wales. HIW's primary focus is on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales
- improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- strengthening the voice of patients and the pubic in the way health services are reviewed
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As a part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services, to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of the Welsh Ministers and, although part of the Welsh Government, protocols have been established to safeguard its operational autonomy. HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of health care in Wales.

On behalf of Welsh Ministers, HIW monitors the use of the Mental Health Act 1983. This work was previously undertaken by the Mental Health Act Commission before 1st April, 2009. HIW has established the Review Service for Mental Health to carry out this work, which mainly involves:

- visits to patients subject to the powers of the Mental Health Act 1983;

- the provision of a Second Opinion Appointed Doctor (SOAD) service which appoints independent doctors to give a second opinion as a safeguard for patients who either refuse to give consent for certain treatments or are incapable of giving such consent.

HIW publishes an annual report on the outcomes of its Mental Health Act monitoring.

More information is available at www.hiw.org.uk

Care and Social Services Inspectorate Wales

CSSIW regulates social care and early years' services using the regulations and national minimum standards made by the National Assembly for Wales and the Welsh Government. The regulations enable CSSIW to regulate the conduct of establishments and agencies in Wales.

CSSIW carries out its function on behalf of Welsh Ministers and, although it is part of a Department within the Welsh government, there are a number of safeguards in place to ensure its independence.

Three regions (North Wales, South East Wales and South West Wales) are the focus for professional assessment and judgement about services and organisations. They inspect and review local authority social services and regulate and inspect social care and early years' settings and agencies.

The national office provides professional advice to improve services and analyses social care in Wales, delivering reviews based on the analysis. It ensures all processes are simplified and citizen focussed providing ongoing communication and engagement with all of our stakeholders and those who use social services. There are a number of protocols, concordats and memoranda that set out how CSSIW works with stakeholders, other regulators and inspectorates.

CSSIW has no right of access to a person's private dwelling although organisations providing personal care in these circumstances would be required to register under the Care Standards Act 2000 and to have their business regulated. CSSIW also regulate children's homes and are aware that there has been discussion regarding the route to lawfully deprive a young person of 18 or 19 years of their liberty when still living in a children's home.

CSSIW wants to make sure that service users are at the heart of all it does, and has an engagement strategy which sets out how it will encourage and promote user engagement to drive up quality, listening and responding to what services users tell the inspectorate.

More information is available at www.cssiw.org.uk

Appendix E

List of Relevant Guidance and Information

Mental Capacity Act, 2005 - Code of Practice, issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act

Deprivation of Liberty Safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, Laid before Parliament by the Ministry of Justice

Mental Health Act 1983 Code of Practice for Wales. Issued by the Welsh Assembly Government 2008

Guidance to Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009

Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009

Standard forms and letters for the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009

Mental Capacity (Deprivation of Liberty: Appointment of Relevant person's Representative) (Wales) Regulations 2009

Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about residence) (Wales) Regulations 2009

Other documents which were considered when compiling the Annual Report:

Social Care Institute for Excellence (SCIE)
Guidance on Deprivation of Liberty Safeguards (At a Glance 43)
www.scie.org.uk

The Mental Health Act 2007: a review of its implementation
Mental health Alliance (May 2012)
www.mentalhealthalliance.org.uk

Care Quality Commission Monitoring 2nd Annual Report on the Deprivation of liberty Safeguards, published March 2012
www.cqc.org.uk

www.mentalhealthlaw.org.uk