National Review of the use of Deprivation of Liberty Safeguards (DoLS) in Wales 2014

City and County Cardiff County Council
Cardiff & Vale University Health Board

9 – 11 April 2014

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NATIONAL REVIEW OF THE USE OF DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) IN WALES 2014

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National Review

The Mental Capacity Act 2005 (MCA 2005) provides the statutory framework for acting and making decisions on behalf of people who lack the capacity to make decisions for them. The Deprivation of Liberty safeguards (DoLS) were subsequently introduced to provide a legal framework for situations where someone may be deprived of their liberty within the meaning of article 5 of the European Convention of Human Rights (ECHR).

The safeguards can be applied to individuals over the age of 18 who have a mental disorder and do not have the cognitive ability (mental capacity) to make decisions for themselves.

This report provides an overview of the use of deprivation of liberty safeguards in this Local Authority (LA) and Local Health Board (LHB). The fieldwork was carried out as part of Care Social Services Inspectorate Wales (CSSIW) and Healthcare Inspectorate Wales (HIW) national thematic inspection of the Deprivation of Liberty Safeguards in Wales. The inspection took place shortly after the Supreme Court handed down a judgment in the case of P and Cheshire West which has contributed to an increase in DoLS applications.

The national review involved a survey of all LHB's and local authorities and 3 days fieldwork conducted in 7 local authorities and all the LHB's between April and May 2014. The findings from the individual inspections will inform a CSSIW/HIW national overview report to be published later this year.

The objectives were as follows: -

- To establish whether DoLs are effective in keeping people safe and that they are not being deprived of their liberty unnecessarily or without appropriate safeguards in place.
- To review how the DoLs Code of Practice is being implemented in practice and determine whether the guidance should be revised and updated.
- To investigate what contributes to inconsistencies in the use of DoLs across the Welsh LA's and LHB's.
- To identify if health and social care practitioners have the awareness, knowledge and skills to fulfil their respective responsibilities to effectively apply and manage DoLs when appropriate.
- To understand the experience of individuals and carers
- To identify and report good practice.

Introduction

Cardiff Council (the Council) and Cardiff & Vale University Health Board (the UHB) have shared arrangements in place for the management of their supervisory responsibilities for DoLS, together with the Vale of Glamorgan Council. This has been in place since the introduction of DoLS in 2009 and is based in Vale of Glamorgan Council Offices in Barry. The team consists of 1 full time administrator and 2 full time DoLS/MCA Coordinators.

Operational responsibility for the team rests with the Vale of Glamorgan Council through a tripartite steering group consisting of representatives from all 3 organisations. The Operational Manager for Mental Health, employed by the Vale of Glamorgan Council, has the day to day management responsibility for the team on behalf of the DoLS Partnership Board. The main functions of the team are: -

- Coordination and supervision of Best Interest Assessors (BIAs)
- Advice and support to health & social care teams in relation to MCA & DoLS
- To provide training for managing authorities, care homes and hospitals

1. Quality of Applications & Assessment

The identification of current and potential deprivations of liberty by managing authorities (MAs) in care homes in Cardiff and consequent applications are most often triggered by the managing authority themselves and some are triggered at the time of a placement being made by the Social Worker involved. However the overall number of applications was very low when considering the number and range of care homes in Cardiff Council area. In 2013/14 the council had 24 applications and the UHB, 54.

Overall, the quality of the Managing Authority applications seen was adequate but some lacked detail and accuracy and had gaps in information. This indicates that the managing authorities involved do not fully understand the process and some are unfamiliar with the documentation. The DoLS coordinators screen all the applications and supporting paperwork and take the view that it is better to receive applications and act on them, rather for them to be perfect in every case. Assessments therefore were not always completed as required by the DoLS Code of Practice e.g. options not deleted as appropriate and dates were missing. These omissions could render individual applications invalid, which in turn may mean that some people are unlawfully deprived of their liberty at a given point.

The Council assessment and care management staff interviewed had only a limited understanding of their responsibilities to raise DoLS through reviews or as a potential DoLS when placing people in a care home. However the group was small in number and did not include staff from the Learning Disability

Teams who had demonstrated a much greater understanding of DoLS on an individual basis through the cases examined.

Inspectors found that there was limited understanding of MCA and DoLS amongst health professionals in ward settings where individual patients are viewed as having "limited capacity". There was also confusion amongst staff between what constitutes a deprivation of liberty and what a restriction and the former is only considered if the individual had made attempts to leave the hospital or expressed a wish to leave the hospital premises before being formerly discharged.

The staff interviewed across the UHB and social care also reported that they find the MCA complex and burdensome. In particular the requirement to make a new application each time a potential DoLS is identified. However, we found that the awareness of staff on wards such as neurology and older people was greater than the knowledge on general medical wards.

There was a perception amongst staff, mentioned on a number of separate occasions that the MHA “trumps” the MCA and the former would always be used as the preferred means of dealing with an individual who needs to be deprived of their liberty. This is supported by the fact that no DoLS applications had been received from mental health wards and care settings, although we were told there are people who were potentially deprived of their liberty and who were not subject to either.

The joint DoLS team were experiencing challenges in effective operation due to the different IT systems that are in place across Health and Social Care organisations. Applications are faxed to the DoLS team and the files relating to each application are then held on paper files. This was a difficulty for professionals involved in the care of individual’s to establish when a DoLS was in place. Arrangements need to be put in place to ensure a DoLS application can be flagged across the different systems to enable professionals to be aware of individual’s current position in relation to DoLS. Hospital based staff in particular described the difficulties they faced in gaining access to fax machines on a 24 hour basis which has resulted in delayed applications to the Supervisory Body.

None of the staff interviewed had experience of Court of Protection applications. The Court of Protection Team which is based in Cardiff was reported as being very supportive but were not made available for interview during the review.

2. Quality of Outcomes

A number of the DoLS applications that were case tracked were very complex and had conditions attached as recommended by the BIA. However, the conditions were not always understood by the managing authority as requiring

their oversight or reflected in the relevant person's care and support plans, including those in hospital.

Where conditions were being used appropriately, they were very creative and effective in reducing the deprivation including supporting the individual to access the community, family life and increasing their safety. In two of the cases seen very specific conditions were put in place for younger adults who required additional resources, this was not reflected in similar situations for older adults.

The responsibility for monitoring the care and support arrangements of the relevant person rests with the managing authority to make sure that the qualifying requirements are still applicable. However, in practice the reviews in the Care Homes were prompted by the DoLS coordinator and care management reviews were not integrated with the DoLS review. This limited the SB's ability to understand how effective the safeguards and any conditions imposed have been in minimising the time or extent of the deprivation. In the UHB staff reported that they had a limited understanding of the DoLS review process , however the DoLS Coordinator described steps being taken to address this.

Within learning disability services a team manager is being put in place to review all service users to make sure they are receiving the care arrangements they need. We were told that this has been identified as an opportunity to consider MCA & DoLS issues as part of this process, particularly in view of the Supreme Court judgment.

Where DoLS have been put in place, managers and staff within care homes reported that it had helped them to support people with challenging behaviour more effectively, as there was a legal framework in place which had been agreed by a number of professionals and would be reviewed.

3. Engaging service users, patients and carers

Very few of the cases reviewed had a Relevant Persons Representative (RPR) identified. Where they were, the relevant person and the RPR had been provided with information about DoLS in the form of a leaflet and access to advice and guidance from the DoLS coordinator The UHB staff reported that they had access to an electronic version of a DoLS information toolkit which could be printed off for patients including an easy read version. However not all staff interviewed were aware of this resource.

The stakeholder representatives interviewed were from the third sector and were limited in number. They had limited awareness of the Mental Capacity Act and little knowledge or direct experience of DoLS.

There was evidence that cultural needs had been identified and were reflected in the assessment and care and support plans. A patient with

hearing loss had been appropriately supported to help understand the DoLS application by the BIA in hospital. There is a complaints process for the DoLS team as part of the service agreement but we did not see any information on individual complaints or any data. The Director for Health and Social Care stated that she and her partners in the tripartite management board would consider any complaints, but there have been none to her knowledge.

4. Quality of Workforce

The DoLS Coordinator for Cardiff is knowledgeable and experienced and her advice and support is valued by the MAs we spoke to. At the time of the inspection the second DoLS Coordinator post was vacant and this inevitably had put additional pressure on the remaining postholder. The recruitment process to fill the vacancy was underway.

Individual MAs in Cardiff have very limited understanding of DoLS and appear to rely heavily on the DoLS Coordinator to support them though the process. There was limited evidence that they understand the purpose of DoLS beyond being able to prevent someone from leaving the premises for their own safety.

The DoLS team do take opportunities to highlight good practice and send out updates across the Council and LHB. Leaflets are distributed to the Registered Managers and a survey of all care home providers has been undertaken asking for information and inviting them to be in contact with the DoLS team about training needs and also for support and advice regarding DoLS.

The Cardiff & Vale DoLS service has access to 23 Best Interest Assessors (BIAs) which was considered by them to be sufficient for the volume of applications at the time of the inspection. The professional background of BIAs was predominately from the NHS and included a wide range of experience from Psychology, Occupational Therapy, Nursing and Social Work. All were very committed to the role of BIA which provides a very strong and rich professional resource for the delivery of the DoLS functions in Cardiff.

BIAs normally would only be needed once per month to undertake assessments. This has previously been a concern in relation to the maintenance of their skills for BIA work. BIAs reported that if they are not needed to undertake work while on the rota some will volunteer when an assessment is needed so that they can maintain and develop their experience.

Where there are BIAs within a health or social care team, there is evidence that this raises everyone's awareness of MCA and DoLS and they act as an expert resource for the team. For example, there are BIA's within the Learning Disability teams who have a high level of expertise and provide advice to other team members about DoLs. BIAs are recruited on a voluntary basis and

see it as a professional development opportunity. In the past it has proved difficult to recruit BIAs as it is seen as an “add on” to their substantive role and they have to be freed up from their other responsibilities. It was pointed out by the BIAs interviewed, that Approved Mental Health Practitioners (AMHP’s) have access to far more training and support than BIAs.

The number of referrals to the Independent Mental Capacity Assessor (IMCA) service is very low when compared to the volume of DoLS applications and activity in other areas in Wales. Referrals came from the DoLS service or BIAs but there is a perception, expressed by the IMCAs, that their role is not actively promoted.

The DoLS team offer training to staff in care homes, social services teams and hospitals. In 2013/14 over 300 staff in care homes had been trained, but only 22 staff in hospitals across Cardiff and the Vale of Glamorgan had taken up the offer. Access to advice and training within the managing authorities themselves was not evident and was not mandatory in the UHB. However the UHB did access the DoLS coordinator and also the BIAs who they reported had provided excellent advice and information.

The Code of Practice has not been made available to staff at Cardiff Council and they have to access and if necessary purchase their own copies. Training was provided to social services staff when DoLS was introduced in 2009, but since then it has been delivered on a more ad hoc basis through the DoLS coordinators attending team meetings, 78 staff had received some level of training in this way. The Code of Practice was also available to staff in the UHB via the intranet.

5. Leadership and governance

Annual reports on DoLS had been made to the Strategic Partnership Board; however they have focussed on activity and not on outcomes. The DoLS team also described the reporting arrangements to the UHB Mental Health Legislation Committee, stating that this gives them a greater profile. The UHB has in place arrangements to provide a clear separation of their managing authority responsibilities at ward/service level and supervisory body responsibilities at executive level.

An internal audit of the DoLS teams performance and the quality of assessments has been conducted by the Manager responsible for DoLS and a draft action plan produced. This aimed to address future demands but had very ambitious timescales and appeared to rely on the existing Manager and DoLS Coordinators to deliver the actions without any additional resource. The Council’s Director of Heath and Social Care has also placed DoLS on the corporate risk register and would like to see better understanding of the issues within the executive board and strengthened governance arrangements across health and social care.

The current service specification for residential care, nursing care and continuing health care, does not require staff in provider organisations to be trained in the MCA or DoLS. The quality assurance process by the Council also did not reference MCA or DoLS. The Director of Heath and Social Care was familiar with the Code of Practice and its requirements and how they applied to the arrangements in Cardiff.

The Council does not have directly provided residential care, however it does have directly provided supported living accommodation, and the Director of Heath and Social Care is the Responsible Individual. In order to be compliant with the Code of Practice requirement for separation of the SB and MA roles, the Director has made arrangements for the Statutory Director of Social Services to oversee any future issues on deprivation of liberty that might come via Court of Protection in supported accommodation.

The joint service arrangements for the DoLS team has allowed the three supervisory bodies to ensure sufficient resources are deployed to receive applications and make assessments in a timely manner. However, individual case follow up after authorisation through care management teams needs further development and also a stronger connection to care management reviews. There are multi-disciplinary teams, e.g. mental health, learning disability and hospital discharge in place that could facilitate this but the MCA is not embedded into their practice.

RECOMMENDATIONS: -

1. When reviewing the DoLS service resources & BIA capacity in the light of the Supreme Court judgment, the Council should develop a strategy which ensures the BIA function is established in all adult services and teams and is embedded in assessment and reviews.

2. The Council and the Health Board should ensure that Mental Capacity Act and DoLS training for managers and staff in all relevant social and health care settings becomes mandatory. They should reflect the requirement for mandatory training in their contracts with managing authorities and audit the effectiveness of this training.

3. The Council and UHB should develop joint systems and processes which support the effective delivery of the DoLS service including the quality assurance of applications and ensuring that an individual's DoLS status is know to the professionals involved with them.

4. The Council and UHB should develop information and tools for their staff that promote a better understanding of the role of the IMCA and when they should be used.

5. The Council and UHB should ensure RPRs are always appointed where possible and appropriately supported in their role.

6. The capacity of the DoLS team should be reviewed by the Council, UHB and partners to ensure it has the resources to meet the demand and range of functions it provides, particularly in the light of the Supreme Court Judgment.

7. The Council and the Health Board should review their engagement with the relevant person, their families and informal carers and implement feedback on the clarity of information already available. They should include details of how to express compliments, concerns and complaints