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

Carmarthenshire County Council
Hywel Dda University Health Board

13 – 15 May 2014

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Merthyr Tydfil
CF48 1UZ

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 7900 126
Email: cssiw@wales.gsi.gov.uk
Website: www.cssiw.org.uk

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Website: www.hiw.org.uk

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

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HYWEL DDA UNIVERSITY HEALTH BOARD

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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 (COUNCIL) and University Health Board (UHB). The fieldwork was carried out as part of Care and 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 and which has led to an increase in DoLS applications.

The national review involved a survey of all UHB's and local authorities and 3 days fieldwork in 7 local authorities and all the UHB'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 "the Safeguards" in the joint national monitoring report are effective in keeping people safe and that the relevant person/individuals 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 Council's and UHB'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

The two organisations inspected, Carmarthenshire County Council (the Council) and Hywel Dda University Health Board (UHB), manage their DoLS

functions separately and each has their own DoLS coordinator/manager. The Senior Manager for Mental Health and Learning Disabilities in the Council is the DoLS coordinator and is supported by a business support role in the Council and there is a dedicated DoLS coordinator in UHB.

The Council has in house care home provision and therefore has both supervisory body and managing authority responsibilities under the DoLS legislation. The Council and UHB do not share Best Interest Assessors (BIAs) with each other or other partners but can attend the BIA practice exchange, however, this is not routine.

The level of DoLS activity between the Council and the UHB has been very different with the Council having the highest number in Wales per 100,000 in 2012/13 and the UHB having a much lower number even though it covers 3 Local Authority areas. However the number in the U HB has increased in 2013/14 to 55 from 7 the previous year.

The Council has developed an action plan in response to the Supreme Court judgment which includes assessing the workforce implications and reviewing the care and support arrangements for people in supported living.

The UHB has also developed a detailed action plan which recommends the creation of additional specialist staff to support identification of potential deprivations of liberty and also the establishment of full-time BIA posts to better meet the demand of the increased numbers of applications. This action plan is being monitored by the Supreme Court Judgment Working Group which is a sub group of the UHB's MCA Steering Group.

1. Quality of Applications & Assessment

In the Council DoLS applications are faxed to the DoLS administrator and the Managing Authorities (MAs) are encouraged to ask advice from the DoLS manager. We saw a number of examples where this had meant that an application was not made as the MA was encouraged to consider a less restrictive option. The Council has a set of standard forms based on the Code of Practice and the assessments are coordinated by the business support for the DoLS service. The MAs (care homes) on the whole had a very good level of understanding of DoLS and were aware of the process.

The cases tracked by inspectors were all completed within the required timescales and had detailed and thorough assessment information. The BIA assessments were of a high standard and included contextual information and a consideration of risk. Of the case files sampled the assessments completed by the BIAs from the Community Resource Teams were more detailed than those done by AMHP's, as they were more focussed on the least restrictive options and had a better understanding of the needs and services for older people and those with physical and learning disabilities who are often most often the Relevant Person (RP).

The documentation is very clear and the DOLS co-ordinator has developed a set of sample forms to share with managing authorities which help them understand the level of detail that is expected for each application.

The Council had in place very clear documentation, particularly the letter to the MAs informing them that a DoLS had been authorised. It includes a step by step list and clear description and of the MA's responsibilities and advice on how to explain the DoLS to the relevant person and the role of the Relevant Person's Representative (RPR).

GOOD PRACTICE

Carmarthenshire County Council

The Council carried out an audit of how effective the BIA service was and how they were working with RPRs. This was the first audit of its kind in Wales and included questionnaires which were sent to RPRs and auditing assessment against a tool developed for the purpose. The findings were used to inform improvements made in the quality of assessments and the knowledge base of the BIA pool.

On the whole the Council had been very successful in getting the message about DoLS out to its MA community and has well developed mechanisms in place for supporting them in their role. However in one of the cases seen the MA was unfamiliar with the qualifying requirements for DoLS and the standard application was poorly completed with inadequate information. The MA had not discussed the matter with the DoLS coordinator prior to submitting it and application was not authorised. On visiting the care home it was evident that there were potentially other people who were deprived of their liberty because of the MAs practice of locking bedroom doors when not in use.

None of the cases seen had Court of Protection applications and so no information was available to explore this aspect of the MCA further during the inspection.

The cases tracked by inspectors in the UHB were all completed within the required timescales, were highly detailed and contained thorough assessment information. The BIA assessments were of a very high standard.

Deprivations and potential deprivations were not identified promptly by all clinicians in hospitals within the UHB. It was reported to us through discussions with staff that Section 2 of the MHA (1983) may be used rather than the DoLs process; however they were becoming more receptive to dialogue about DoLS in the MDT meetings. There has been an improvement in their identification of DoLS since the current DoLS co-ordinator came into post and they were increasingly being considered and, as noted previously, there has been a significant increase in numbers. However a perception

persists that only patients who demand to leave the ward and attempt to leave the ward need to be considered for DoLS application. Other patients who could be eligible for DoLS may go unnoticed.

Community Mental Health Team (CMHT) nursing staff carry out assessments and reviews in care homes with nursing and advise them on DoLS referrals and how to manage situations i.e. to minimise potential restrictions. They also found that staff were beginning to consider DoLS as part of the routine assessment process.

Health staff that were interviewed considered the DoLS process to be overly technical, complicated and therefore daunting for staff. However they had not fully considered the significance of the consequences of depriving someone of their liberty when they do not have the capacity to consent.

The UHB has a DoLS good practice information folder available on the wards with information for staff about DoLS. Staff stated that they could contact the supervisory body for guidance and also had access to the link nurse within the MA for support and professional advice.

The DoLS coordinator for the UHB quality checks applications that are received by the supervisory body and if the application is deemed to lack quality or is incomplete, the ward will be contacted and asked to resubmit. The UHB was in the process of circulating “exemplar” forms to the MAs to help them understand what was required.

GOOD PRACTICE

2. Quality of Outcomes

There was evidence of a multidisciplinary approach in the care homes visited and support was accessed from a wide range of professionals to achieve the best possible outcomes for people.

The care and support plans seen during the inspection reflected the individuals’ needs and any conditions attached to the DoLS authorisation. For example one person’s patterns of behaviour were mapped by use of an appropriate tool which also recorded their inability to consent to interventions, a lack of insight into their own vulnerability and the associated risks with this.

However conditions were not widely used in the sample seen, and the practice of limiting the time span for authorisations to the minimum, although considered good practice, meant that sometimes the situation had not changed and further authorisations were required. Where conditions were put in place, the MAs were not always aware of them or their role in fulfilling them.

Inspectors saw evidence of improved outcomes for individuals as a result of DoLS put in place. For example, one person was reassessed for nursing level

care which led to increased staffing levels and an improvement in her safety and so the DoLS authorisation was no longer required.

Hospital staff stated that outcomes for patients with DoLS in place have sometimes led to delays in their discharge. For example a suitable onward placement had not been found which had led to them remaining in hospital for longer with all the inherent risks that this presented. In one case seen in a hospital setting, a DoLS condition relating to the relevant person's discharge was not met , however, the MA were diligent in ensuring they had another authorisation put in place. Staff also requested extra staffing for supervision and made all staff aware of patients' situation under DoLS and the risks he presented with.

3. Engaging Service Users, Patients and Carers

We found that there were RPRs in place for the cases seen and they were most often family members, however it was mentioned by the staff interviewed that, often the family were in agreement with the DoLS and so it might be considered that they don't always present sufficient challenge. This is not an issue specific to Carmarthenshire and they adhere to good practice in terms of identifying and appointing RPRs wherever possible.

The IMCA service has been recently retendered and Mental Health Matters took over contract in March 2014. The advocates have transferred with the service, and so have historic knowledge of the IMCA arrangements in Carmarthenshire. They stated that referrals from the Council were low – circa 6 per year; and there was scope for an increase, especially given the Supreme Court judgment. An advocate is able to respond promptly to referrals, visiting as soon as possible and always confirming arrangements in writing. In the course of general advocacy work they have referred other cases for consideration of DoLS and in their experience awareness in care homes is "variable" and in psychiatric wards, staff are often in a "muddle" between MHA and MCA provisions - though this is improving and the role of the advocate generally has become more understood over time.

The Council has access to 4 Welsh speaking advocates and also one who speaks Polish. We were provided with copies of the DoLS documentation translated into Italian as this was the relevant person's first language. Easy read versions of DoLS information and letters are readily available.

The UHB have distributed posters, flow charts and leaflets which are available in both English and Welsh. These are available to staff, patients or relatives. This was evidenced on the field trips during the inspection. However day to day practice reflects that individual cases are still being discussed with link staff.

The family members spoken to were provided with information and kept informed and also consulted extensively by the BIA. This was confirmed

through examination of correspondence within the patient's case notes. Copies of letters to the RPR about both the DoLs applications were requested and evidenced this. Information leaflets were also made available to patients family.

4. Quality of Workforce

The management of the DoLS supervisory function is hosted within the Mental Health and Learning Disability division of the Council and is the responsibility of the Senior Manager for Learning Disabilities and Mental Health. This provides a clear separation from the MA function as the Council has in-house care home provision. The DoLS supervisory function previously took up 25% of the DoLS lead manager's role but, at the time of the inspection, it had dramatically increased to circa 90% as the impact of the Supreme Court Judgment translates into more applications and requests for advice. The Senior Management Team of the Council is considering the future sustainability of these current arrangements and future options. At the time of the inspection there were 2 professional leads practicing as BIAs and a 3rd was in training.

A DoLS practice exchange forum is held quarterly within the council that has a quality assurance function and is used to discuss and debate some of the complex cases and ensure consistency and promote good practice. This is attended by the Council BIA's and Section 12 Doctors. The merging of the practice forums with UHB had been discussed and the UHB DoLS coordinator had been invited to attend one of the meetings. There are also regular group supervision sessions and update training available to UHB BIAs from a Senior Law lecturer at Swansea University.

There are 4 Section 12 Doctors, 3 of whom are old age psychiatrists and 1 a Learning Disability psychiatrist but there were concerns about the increase in demand as training for Section12 Doctors is only available in North Wales. The Welsh Government grant is used to fund this capacity.

The Council has access to 17 BIAs with a further 3 undertaking training and is considering the workforce demand implications of the Supreme Court judgement. All AMHP's have the BIA role written into their authorisation, an approach decided on by the Council when introducing DoLS in 2009. It believed that there was a strong alignment between these two roles and this group of professionals had the skills to tackle the application of a new and complex piece of legislation. However this BIA resource has now been expanded to include other roles as the majority of the AMHPs do not work in older people or learning disability services where DoLS applications are most often raised. There were 5 Community Resource Team Social Workers who are BIAs, they are self selected. There is no financial incentive to take on this role. The AMHP's are required to submit a CPD portfolio and it was suggested by the Social Workers interviewed that this approach could be adapted for all BIAs.

In 2011 the Council carried out an internal audit to find out how effective the BIA service was and how they interacted with the RPRs. This was the first audit of its kind to be undertaken in Wales and questionnaires were sent to RPR's and a sampling of assessments were assessed against an audit tool devised by the professional lead and DoLS Manager. The findings highlighted that improvements were needed in the level of detail recorded and the knowledge base of the BIA pool. This had led to a review of the BIA workforce by the Council. However, although the audit did ask questions about the outcomes for the RPs such as use of the balance sheet in considering support arrangements, there were no recommendations linked to this.

The focus group with care managers was well attended. They spoke about mental capacity and DoLs as a routine part of their job, and not something additional. This showed a good level of understanding and a commitment by staff to applying the legislation appropriately. BIAs were available in all Community Resource Teams but it was felt that there were too few in some areas e.g. Llanelli. The BIAs are organised on a cab rank basis covering different geographical areas to their home team and this has worked well. There are no plans to share capacity with the UHB or neighbouring councils.

The MAs reported that the DoLS Manager and the BIAs had been an excellent source of advice and support. A very proactive approach is taken to DoLS by the Council who also provide training for them, but it is often oversubscribed and should not be the only source of training that individual MAs access as it the latter's responsibility to ensure that their staff understand their contribution to DoLS.

At the time of the review the UHB only had access to 4 BIAs but was considering how to increase this pool, including options for sharing the resource to increase efficiency as it has a very large geographical footprint to cover. They also need to ensure separation of roles in any future arrangements. The BIAs in the UHB were on call on alternative weeks. The Supreme Court judgment had led to an increase in demand and the Supervisory Body had written to the MA to explain the reasons. It was also anticipated that the current BIA capacity would be insufficient to meet future demand.

Staff spoke highly of the MCA lead in the UHB and said they were extremely knowledgeable and always available to provide support. The DoLs Coordinator had raised awareness amongst UHB staff through for example attending handover meetings and talking to staff in Accident and Emergency departments.

There is a rolling programme of MCA training of which DoLS is a component and is not mandatory. There are also shared learning opportunities with the Council and other neighbouring UHBs. One consultant spoken to was clear that he and his colleagues would require further training and would be advocating that all his team were trained in the use of DoLS.

5. Leadership and governance

The Council has clear governance arrangements for the exercise of its supervisory body responsibilities for DoLs which covers the management, practice and learning and development functions.

There are a number of strategic partnership arrangements locally which are relevant to and supported the effective management of DoLS functions. These include an MCA board which consisted of the 3 Councils and the UHB and which in turn reports on DoLS activity and issues to the Adult Safeguarding Board.

In the Council the DoLS Manager reports directly on DoLS to the senior management team, and when required to the Executive Board of the Council. A report on DoLS is also included in the Director of Social Services annual report and there are explicit governance and reporting arrangements for DoLS set out by the Council.

In the UHB the Deputy Director of Primary, Mental Health, Community and Long Term Care, is the strategic lead for the supervisory body within the UHB. The Head of Clinical Effectiveness is the strategic lead for the MCA as a whole and the managing authority functions under the DoLS. The former is the nominated signatory for the supervisory body function with agreed arrangements that the Head of Long Term Care can deputise in this role when necessary.

The MH and LD team across health and social care are "joint" but are not integrated and there are no immediate plans to merge the management of DoLS at an operational or strategic level.

There are strong links between the DoLS supervisory functions and the commissioning and community resource teams which are collocated and communication is therefore easy. There are joint meetings between health and social care to look at safeguarding, restrictive practice, escalating concerns and this traffic light system also influences commissioning and contracting with care homes.

The Council has in place a set of local policy & procedures for DoLS which are very clear and have useful flow charts which ensure consistency in application. They are very active in the All Wales MCA network and have adopted their guidelines for BIA assessments in Carmarthenshire.

The UHB had developed policies and procedures relating to DoLS and all hospital wards had access to a DoLS folder which had contributed to an improved awareness amongst staff and better access to the information they required.

Recommendations

1. The Council should review current practice for DoLS including the length of authorisations and encourage the use of conditions where necessary to achieve improved outcomes for the Relevant Person.

2. The Council and the UHB 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. They should audit the effectiveness of training.

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

4. The Council and the Health Board should each review the Section 12 doctor capacity to ensure that they are able to meet the requirements of the legislation and the Supreme Court judgment.

5. 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 across all adult services and teams and the MCA is embedded in assessment and reviews. Options for sharing this resource should also be considered with partner organisations including the UHB.