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

Gwynedd Local Authority
Betsi Cadwaladr University Health Board

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

GWYNEDD LOCAL AUTHORITY
BETSI CADWALADR UNIVERSITY HEALTH BOARD

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 Council and University Health Board (UHB). 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.

Findings from the individual local authority 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 LAs and UHBs.
- 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

Gwynedd Council covers the most westerly part of North West Wales and this large area is divided into three divisions within social services. Betsi Cadwaladr University Health Board covers the whole of North Wales, relating to six councils within the area. Each organisation manages DoLS very separately with no partnership arrangements, apart from practice networks beginning to develop across the whole of North Wales.

The Council and the Health Board each hold both supervisory body and managing authority responsibilities[1]. Each organisation carries out its own supervisory body functions which broadly involve receiving applications, arranging assessments including those by Best Interests Assessors[2] (BIAs) and Section 12 doctors[3], process co-ordination, consideration of BIA recommendations and authorisation of deprivation of liberty applications by designated signatories.

Where Gwynedd residents are placed in care homes in England, the Council generally arranges for BIAs from English supervisory bodies to carry out the assessments but retains the responsibility for granting authorisations. As well as commissioning care home beds for its citizens wherever they are required, the Council has care homes that it directly manages.

The Health Board provides a wide range of in-patient care including specialist treatment within hospitals across North Wales. It is also a provider of Mental Health Care Services in and for Powys.

In 2013-14 a total of 7 applications were received by the Council, with four authorised. The Health Board which covers a much larger area, received 27. There was one third party application[4] to the Health Board. In 2012-13 [5], the number of applications received by supervisory bodies was considered across Wales as a proportion of 100,000 population enabling comparison between them. Compared with other Welsh councils, Gwynedd Council received a low proportion of applications from care homes with only two other councils receiving fewer proportionate to their respective populations. The Health Board also received a comparatively low level from healthcare settings proportionate to its population with only one other health board receiving fewer.

1. Quality of Applications & Assessment

The Council has received few applications since 2009. One year, it received none. In 2013-14 the Council commissioned placements from 33 independent care homes and provided placements in its 14 care homes. A higher number of applications could be expected across this range. However, since the Supreme Court judgment[6], five applications were received in April 2014 and a further 12 by mid-May. This suggests that managing authority providers are now recognising deprivations of liberty which need to be validated, and raises some concerns about the previous low level of

[1] See Glossary for further explanation of terms used in the legislation
[2] See Glossary
[3] See Glossary
[4] See Glossary
[5] Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care. CSSIW and HIW, published February, 2014
[6] See Glossary

applications. There were no third party applications recorded, although an Independent Mental Capacity Advocate[7] (IMCA) consulted in a wider Mental Capacity Act Best Interests decision, was instrumental in getting a deprivation of liberty recognised. It was subsequently authorised.

The quality of the applications from managing authorities was very varied. They tended to be made in response to members of multi-agency teams or individual practitioners involved in discharging patients from hospital suggesting that the Safeguards would be necessary. They are sent to an operational service manager who has the lead for DoLS supported by an administrative officer. This service manager also has wider responsibilities for Adult Services within Social Services. Despite the availability of advice, managing authority representatives contacted during the inspection indicated that they found the DoLS framework confusing and did not see the Safeguards as benefitting the relevant person[8]. We found errors in the details supplied in applications, for example where deletions on the forms were not made. These are important as the questions posed in the forms may be of an "either/or" format, so that failure to delete one or the other results in inaccurate information.

The Council has trained 9 BIAs from its adult care management teams, who are all social workers. All of the BIA assessors have to balance their DoLs work with their other casework or management responsibilities. There are arrangements to ensure independence and BIAs do not take on assessments for people supported in their own teams or divisions. The quality of assessments was mixed, with BIAs setting out detailed content and measured judgement, but some made process errors. In one example, there were contradictory deletions so that on one page it appeared that authorisation was being recommended, whereas on the other it was clear that it was not. This relevant person had been subject to a previous authorisation and it is possible that this compounded the errors. There was a general failure to delete some sections of the forms. Applications and assessments are therefore not always completed according to the requirements of the Code of Practice.

More attention needs to be given to quality assurance of all documentation. Inaccuracy in some details, such as dates, could invalidate authorisations and leave the Council open to censure. Applications and assessments are discussed with a solicitor in its legal services which offers a further opportunity for quality assurance. In order to improve practice and ensure that Code of Practice standards are met, stronger quality assurance arrangements for completed forms for application and assessment are required.

The Council's legal services make any applications to the Court of Protection[9], although none have so far been made.

In the UHB deprivations and potential deprivations are generally identified promptly by managing authorities (designated ward staff) and authorisation

[7] See Glossary
[8] See Glossary
[9] See Glossary

sought in advance. Where possible, the need for assessment is identified pre-admission and processed rapidly. The overall quality of applications examined was satisfactory. Managing authority staff indicated to inspectors that the application process is very lengthy and complex, requiring much more detailed information than the four pages required in Welsh Government guidance. The Health Board changed to use the Department of Health recommended forms which enhanced the level of information required to ensure accuracy but this policy has had consequences. Inspectors spoke to a ward manager responsible for making applications who said that she intended to make an application for a standard authorisation regarding an agitated patient; however, this could not be completed while she was the only member of staff available to give the patient one to one attention. It was not clear whether the manager had already put an urgent authorisation in place. We were told that this was an isolated example but the Health Board should consider if changes are required to the application process.

The medical director indicated that there were fewer DoLS referrals than he would have anticipated and felt that further training was necessary. He has also requested that DoLS activity be reported to the UHB Board as part of the Quality Assurance process.

The UHB have five BIAs who work across North Wales. Inspectors met 4 BIAs of the 5 who cover the whole UHB footprint. The practitioners have worked or are currently working with people with learning disabilities. They are supported by the Health Board's lead officer for the Mental Capacity Act and DoLS and a senior BIA. They do not work with any patient for whom they have direct responsibility.

The quality of their assessments was generally satisfactory, although on some examples the inspectors noted omission of details, such as whether an IMCA was required, and an assessment that did not evidence decision making capacity. The BIAs are expected to use a Best Interests Balance Sheet to summarise the information gathered and inform decision making which was apparent in one of the cases tracked where the rationale was clear and evidenced. The UHB's signatories for authorisations are the final point of quality assurance. In order to improve practice and ensure that Code of Practice standards are met, stronger quality assurance on completed forms for application and assessment is required.

The Health Board is responsible for approving and training section 12(2) Doctors in Wales who may be asked to complete the mental health and eligibility assessments for Health Boards and Councils. To date the same team has had responsibility for the DoLS Supervisory Body functions for the Health Board and the responsibility for approving and training section 12(2) Doctors and Approved Clinicians in Wales. The all Wales responsibilities have provided the opportunity to ensure the section 12(2) Doctors and Approved Clinicians has included DoLS in the mandatory induction and refresher training, although this is not a requirement in Wales for section 12 (2) Doctors. The Health Board has made no applications to the Court of Protection in recent years.

2. Quality of Outcomes

BIAs working for the Council confirmed that it was possible to commission less restrictive arrangements, thus avoiding a deprivation of liberty. They recommend this action wherever possible and inspectors read about examples where it had occurred. However, inspectors also examined an authorised detention for a relevant person placed in a care home in England where the commissioned BIA had recommended additional support. The Council did not fund it nor did it review the general outcome of the relevant person's care in a timely way. Wider independent review comes through care management oversight required in other guidance.

Inspectors considered the outcome of another authorised deprivation of liberty by meeting the relevant person and his representative. It was clear that the family member was torn between his father's needs and those of his mother. Inspectors asked the Council to consider the effectiveness of the Relevant Person's Representative[10] (RPR) in these circumstances as it would be possible for an IMCA to take on the role. Although a care management review had taken place, these issues were not taken up and neither had the managing authority asked for a DoLS review.

The Code of Practice expects the managing authority in all eligible settings to monitor the outcomes for the relevant person whose deprivation of liberty is authorised. This is to ensure the authorisation is valid and achieving the required objectives, for example, that the qualifying requirements are still applicable. If necessary they should request the supervisory body to hold a DoLS review. There was little evidence that this occurred in the cases we examined. This may in part be because few BIAs used conditions. The managing authority should also monitor that the relevant person is being well supported by their representative and should notify the supervisory body where this is not happening. Again there was no evidence that this had occurred.

The outcomes for in-patients in hospitals were generally satisfactory. Inspectors visited selected wards across North Wales. In-patient care in the Health Board covers a wide spectrum of conditions and in-patient stays were relatively brief in the circumstances examined. In a number of cases, the individual returned home once treatment was completed. Where 24 hour care was necessary on discharge, the appropriate placement was arranged with the relevant partner council.

In the Health Board files sampled, there were no examples indicated where the Mental Health Act 1983[11] had been used alongside the Mental Capacity Act. Inspectors heard that that the Safeguards were not generally used in

[10] See Glossary
[11] See Glossary

mental health services where the Mental Health Act was applied to in-patients if required. However, it should be noted that the Mental Health Act Code of Practice gives guidance on a range of situations where the wider Mental Capacity Act should be used alongside the Mental Health Act.

3. Engaging Service Users, Patients and Carers

The Council and the Health Board as the respective supervisory bodies are responsible for sending letters to the relevant person, their carers and other interested persons named by the BIA. The letters explain the outcomes of assessment and state whether the BIA's recommendation has been accepted. There was evidence that this had been carried out in a satisfactory manner.

All of the BIAs reported good access to IMCAs, however, not all are able to converse in the Welsh language which could be problematic for patients and service users who use Welsh as their first language. Changes were being made to the service provider during the course of the inspection, and this was an issue due to be resolved. Managing authorities who had contact with IMCAs expressed appreciation of their knowledge and skill. The council's guidance to staff reinforces the importance of the IMCA role in supporting the relevant person where there are no family or friends.

Inspectors had discussions with IMCAs, who gave examples of views different from the Council concerning families and appropriate representation. One considered that known conflicts of interest within a family prior to an individual's placement in a care home should have made an IMCA the proper choice to take on the PRP role. Another had been asked by the Council to take on the RPR role, but thought that there were family members capable of doing so. This suggests an early discussion with the new IMCA service provider is necessary to ensure clarity with regard to referrals to the service. The Health Board commissions the service and joint discussion will be essential.

The DoLS lead officers in each organisation and the BIAs working with them offer advice and information to the relevant person, their representatives and families about assessment and authorisations. After authorisation, managing authorities in care homes and on hospital in-patient wards are required to offer them support, information and advice. They must ensure that their staff have the necessary knowledge to fulfil their responsibilities.

Neither supervisory body had received any complaints about the operation of the DoLS process. However, there is no information that explicitly refers to making a complaint about the DoLS process and this should be remedied.

There was evidence that equality and diversity had been considered in care home placements that the Council made and the resulting care plans. In particular, the linguistic needs, including Welsh language needs, of the service users are always considered.

In hospital settings, the in-patients' care and treatment needs were most likely to dictate where they received treatment. This was often for short periods of time. In the case files examined, there had been appropriate attention to equality and diversity, although it was not always possible to meet linguistic needs, for example those who use Welsh as their first language.

The Health Board provides an information leaflet to RPRs. It also has general information for patients and their families on its website. However, electronic information concerning the Safeguards can only be accessed by a user with particular access permissions, suggesting it is a staff rather than a patient resource.

Inspectors met with a group of stakeholders with representatives from independent not-for-profit organisations, providing support to people in both health and social care settings. Their understanding of the Safeguards varied, depending on the service they provide. The organisations providing input such as advocacy to care homes and the providers of supported accommodation were most aware of the legislation and the implications of the Supreme Court judgment. They have jointly arranged training on its implications and were confident that they will be prepared. They recognise that the Council also needs to be ready for the potentially large number of applications that will have to go through the Court of Protection and have entered into discussion with them.

4. Quality of Workforce

The workforce most directly engaged in DoLS comprises lead officers within the supervisory bodies, administrative support, the assessors including BIAs and Section 12 doctors, and where appropriate IMCAs. Managers and staff in managing authority settings (hospitals and care homes) are the other key group who need to be aware of DoLS and the requirements that apply to them. In Social services, assessment and care management teams need to be familiar with legal requirements including the Mental Capacity Act principles.

Inspectors met a group of Health Board and Council staff working with adults. They were aware of the implications of the Mental Capacity Act, through less familiar with the details of the Safeguards. They expressed positive views about having colleagues who are BIAs.

The low number of applications to the Council means that their individual BIAs do not get frequent opportunities to use their skills and gain experience of a range of people with different needs. Nevertheless, 9 BIAs attended accredited training and there has been regular update training from expert trainers over the years which has supported their knowledge-base. Having practitioners who undertake BI assessments in adult social services raises the level of expertise within their teams and acts as a valuable resource. BIAs get advice from an accessible and knowledgeable operational service manager

who provides effective leadership for the BIA's within the council. The BIAs and managers also benefit from a local practice group that develops and improves practice. They also have access to legal advice from the Council's own solicitors, one of whom has dedicated time for adult services.

The Health Board arranges the training and approval of section 12 (2) Doctors for Wales. A number of the Section 12 (2) Doctors are independent contractors and it was reported there have been occasions when it can be difficult to arrange for assessments from Section 12 doctors, due to pressures of work. The Council's senior managers should discuss this with the Health Board.

The 4 BIAs interviewed from the Health Board all have a similar background in learning disability and mental health services. They expressed some concern that other disciplines in healthcare may not see DoLS as a mainstream issue affecting a wide variety of patients. The senior BIA supports his colleagues, and the health DoLS lead officer is approachable and knowledgeable resource. They have regular team meetings and the new Medical Director and the Assistant Nurse Director for Safeguarding has raised the profile of DoLS with the UHB Board.

BIA update training is commissioned separately by each organisation, although there is some shared training across local councils in North Wales coordinated by the Health Board. The Health Board BIAs have received training from Manchester University and also link with the councils where there is a formal agreement to work in partnership. The Health Board organises and funds joint training for BIAs and Section 12(2) Doctors in North Wales.

There is a joint North Wales BIA practice networks facilitated by the Health Board with opportunities for mutual support for all BIAs and the DoLS leads.

The care home managing authorities from independent settings interviewed all expressed a need for more training and clarification of the implications of the Supreme Court judgment. The Council managing authorities had received recent training on this alongside the BIAs and senior managers, so seemed more confident that they would be able to respond appropriately. They recognised that making a higher number of applications to the Council in a short space of time would stretch resources, but were clear what their responsibilities were as the managing authority. Although the Council provided awareness training in the years following implementation, both their own training schedules and the independent managing authorities revealed that there had been no recent activity through the Social Care Workforce Development Programme[12]. The Council's trainers indicated that low uptake when training was arranged meant that events had to be cancelled, whereas the care providers suggested they had not been given opportunities to attend. This contradiction needs to be examined and resolved. The inspection found

[12] Each council is funded by the Welsh Government to ensure a regular and varied programme of training is accessible to the wider social care workforce.

that the local training and promotion of the DoLS had not resulted in wide awareness and understanding of the Safeguards and its processes.

In the Health Board, there have been opportunities for awareness raising and more detailed training for managing authority ward staff. Inspectors saw detailed schedules of the extensive training provided together with feedback from a range of staff who attended and valued the input. This has to be balanced by the difficulties of releasing staff for training. E-learning was not on its own considered to be the most effective way to learn about the Safeguards and its requirements.

5. Leadership and governance

Both the Council and the Health Board have written policies setting out required action from staff and describing individual governance arrangements. In the Health Board DoLS is reported to the Safeguarding Sub Committee and the Mental Health Act Committee and performance is included.

The Council established governance and management arrangements around the Safeguards when they were implemented in 2009. There was a clear framework, with clarity about the separate roles of the supervisory body and the council provider managing authorities. There are separate policies for the supervisory body and the managing authority functions. The supervisory body policy was updated in March 2014. It gives guidance to the BIAs and names the three designated signatories to authorisations. It also references the Supreme Court judgment and its implications. The signatories all have roles within care management and are separate from in-house care home provision. However, one of the signatories is a senior manager who has not been available due to ill health, leaving the service manager who leads on DoLS to report to the senior management group in Adult Services and maintain their awareness of recent developments. Senior managers have not routinely considered performance management information on the Safeguards. The head of adult services is newly in post but recognised the need to develop aspects of performance management more robustly.

The Council's managing authority policy makes clear that each "Registered Manager" under care standards legislation - that is the manager of each care home - is the Managing Authority. It includes a helpful flow chart for provider managers that requires consideration of how support plans can be amended to avoid a deprivation of liberty. It has not been updated to reflect the Supreme Court Judgement and its definitions of a deprivation of liberty. This needs to be remedied urgently.

Until recently these was an obvious separation of the two functions within the Council. However, the recently appointed Director of Social Services was formerly the head of the operational provider unit and continues to be the Responsible Individual under care standards legislation. Although the DoLS legislation and guidance recognises that a single body can act in both

capacities, it also highlights the potential for conflicts of interests. It recommends a clear separation of the different functions within the management structures of the organisation. The Council needs to consider further its structures to ensure no conflicts of interest exist.

The Council has recognised the potential impact of the Safeguards in commissioning independent care homes. It is a party to the single pre-placement agreement used by all six councils and the Health Board in North Wales. This emphasises the importance of person centred care and references the Mental Capacity Act, its Code of Practice and the Safeguards. It requires each managing authority to have a policy and procedure in place for making applications to deprive someone of their liberty. There is a global reference to staff training within the agreement, prescribing the training required to qualify for the North Wales passport. Contract monitoring officers and the care managers placing and reviewing relevant persons in care homes need to work together to ensure that these requirements are met effectively. Discussion with the lead for commissioning suggests a high level of recognition of the issues and a desire to achieve more. Support from legal services was obtained as part of these developments. This solicitor has undertaken additional training in MCA and DoLS.

Elected members have recently received awareness training on the Mental Capacity Act and the Safeguards. They have been made aware of the potential for increased demand, both from DoLS and because of the need to review whether there are deprivations of liberty in other settings which should be changed or considered by the Court of Protection. The Council are also reviewing past decisions where an application from a care home failed because the care regime was considered to restrict the relevant person's liberty rather than deprive them of it.

Although Mental Capacity Act and DoLS activity has not been regularly reported to the joint Gwynedd and Ynys Mon Local Safeguarding Adults Board, the Director of Social Services indicated that this may occur in future. The Director of Social Services' Annual Statutory report has not previously given information on DoLS.

The Council has developed capacity to undertake Best Interest assessments with management and legal support which will be tested by the increased demand. Senior managers should give particular attention to improving the quality assurance and governance arrangements. There is a need to improve awareness of DoLS and bring greater understanding of its processes within the Council and wider social care sector. Using the Safeguards should be seen as a mainstream activity and core statutory business for staff.

The Health Board has invested significant effort in ensuring written guidance and policies are available to BIAs and ward staff, for example so that they should be able to recognise on admission patients who have difficulty in making decisions about their care and/or treatment. Some of the guidance needs to be up-dated in light of the Supreme Court judgment, although the DoLS lead officers are aware of its implications. They have clearly

designated senior managers who are signatories for the supervisory body functions, including the Medical Director who is Director of Clinical Services. Inspectors met the Medical Director who outlined his proposals to strengthen arrangements further.

Partnership is an important aspect of seamless care in other areas of health and social care such as effective hospital discharge, support to carers and mental health services. There are some existing areas of overlap for example where a relevant person is placed in a care home with nursing, paid for through Continuing Health Care Funding but an authorised deprivation of liberty is also used. The supervisory body in these circumstances is the Council although contract monitoring is undertaken by health practitioners. In Wales there has been no requirement within the Safeguards for health boards and councils to work together, and guidance in place since 2009 states that while health boards may work together and councils may work together, health boards and councils cannot take on each other's supervisory body roles. Although there is no requirement for Betsi Cadwaladr University Health Board and Gwynedd Council to work in partnership on DoLS, the Health Board's activity with another council suggests there can be mutual benefits. An obvious area is in joint training, which already includes Section 12 doctors and BIAs in another area.

Recommendations

1. The Council and Health Board should continue to develop understanding of the Mental Capacity Act, DoLS and the implications of the Supreme Court at all levels. It should ensure that it builds on the existing knowledge and skills of care managers in adult services so that where there are authorised deprivations in place, care management reviews reflect consideration of their outcome and effectiveness. The links between care management and contract monitoring in adult services should be more robust.

2. The Council and Health Board should ensure that it reports performance information on the Safeguards to senior managers and elected members regularly.

3. The Council should examine its management arrangements to ensure that there are no conflicts of interest between its supervisory body and managing authority functions.

4. The Council and the Health Board should each develop more robust quality assurance mechanisms, so that all applications, assessments and authorisations comply with legislation, guidance and case law.

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

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

7. The Council and the Health Board should consider where closer partnership working could bring additional benefits and improve outcomes for the relevant person and their families.

8. The Council and the Health Board should each ensure that Mental Capacity Act and DoLS training for managers and staff in all relevant social and health care settings becomes mandatory and is delivered regularly. They should audit the effectiveness of all such training.