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

Monmouthshire County Council
Aneurin Bevan University Health Board

13 – 15 May 2014

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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

MONMOUTHSHIRE COUNTY COUNCIL
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
13th – 15th May, 2014

The 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 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 LHB's and local authorities and 3 days of 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 "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 Councils and Health Boards.
- 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

Monmouthshire County Council sits alongside four other local authorities within the area often known as Gwent in South East Wales. It has a common boundary with England to the south and east. The Council provides social

care in two care home settings, so it has both supervisory body[1] and managing authority[2] responsibilities. Aneurin Bevan University Health Board covers the Gwent area for its supervisory body responsibilities and has managing authority responsibilities for a wider in-patient population which includes some services in Powys. It provides an extensive range of patient care including specialist treatment. Both organisations commission social and health care services in England where DoLS may be used so also have supervisory body responsibilities for people in these placements.

The five councils and the Health Board jointly fund the Gwent Consortium to maintain an independent Deprivation of Liberty Safeguards (DoLS) team, hosted by the Health Board. When it was set up in 2009, there were different health board structures in place with a co-terminous local health board alongside each council.

Each supervisory body is responsible for considering recommendations and deciding whether to authorise deprivation of liberty applications. They remain accountable for the supervisory body functions carried out on their behalf by the DoLS team.

The team's functions broadly involve the organisation and co-ordination of the DoLS processes - including receiving applications and arranging assessments - and advising managing authorities. The team employs two full-time Best Interests Assessors[3] (BIAs) and an administrator. Together they provide administration for the process, produce regular performance reports and offer some training across the relevant health and social care workforce. Line-management sits within the Primary Care and Networks Division of the Health Board, which is separate from in-patient service provision.

In 2013-14, 10 applications were received by the Council and 28 by the Health Board. In 2012-13 [4], the number of applications received by each supervisory body was considered across Wales as a proportion of 100,000 population enabling comparison between them. Proportionate to their respective populations, the Council and the Health Board each received relatively low level of applications, although the Council received a higher proportion than two other councils within the Gwent Consortium.

1. Quality of Applications & Assessment

The Council provides and commissions a number of care home placements for Monmouthshire residents. The total number of applications is low when compared with the number of settings in which a deprivation may take place and there are care homes where no applications have been made. It was

[1] See Glossary for explanation of terms used within legislation and guidance
[2] See Glossary
[3] See Glossary
[4] Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care. CSSIW and HIW, February, 2014

noticeable that more applications came from a social services-managed care home than from all independent care homes with commissioned places, suggesting good awareness of potential deprivations of liberty. Applications from care homes were also prompted by multi-disciplinary hospital discharge teams when making plans to place the relevant person in 24 hour care because returning to their own home was no longer sustainable.

The quality of examined applications was varied; the best examples were clear on the objectives of a deprivation, and had appropriately recognised the need for an urgent authorisation, while assessments took place. There were examples that did not meet these standards, with few details or a failure to recognise that a deprivation was already taking place (Managing authorities would be expected to have put an urgent authorisation in place in these circumstances.) Within the case files sampled, the applications to the Health Board described patients with very complex circumstances where the Mental Health Act 1983[5] was often considered alongside the Mental Capacity Act and DoLS provisions. The applications to the Council were more straight forward and concerned older people with dementia-type illnesses who had moved from their own homes to a care home but did not accept the new arrangements.

The assessments in the case files examined were good quality, with a thorough examination of circumstances and well presented recommendations from BIAs. Although there had been arrangements for a pool of BIAs drawn from each council in the Consortium to share this work, the BIAs making the assessments were generally from the DoLS team. For several months, there was only one BIA in the team, working under considerable pressure.

A number of errors were found in documentation that had not been picked up at any stage including authorisation. This included the incorrect spelling of the name of the Council supervisory body's designated signatory of authorisations and necessary dates left blank. The quality assurance process needs to be strengthened to ensure the validity of all authorisations, with the authorising supervisory body taking equal responsibility for this.

A few of the social work staff interviewed had experience of Court of Protection[6] applications under the broader requirements of the MCA. The legal team working for the Council makes the applications to the Court and works closely with the social workers throughout. The Health Board and the Council have not referred any relevant persons to the Court for review of a deprivation of liberty.

[5] See Glossary
[6] See Glossary

2. Quality of Outcomes

The quality and range of care home services available to the relevant persons[7] contacted were at least satisfactory, with some providing excellent care. Where suitable facilities are known to be available outside of the area, they are commissioned. Some families also commission care for their relatives where they do not qualify for council funding. These arrangements come to the notice of the Council if the managing authority for the care home recognises a deprivation of liberty. However, the relevant person does not automatically receive the additional protection of care management oversight and review from the Council if they fund their own care. The Code of Practice expects the managing authority to monitor the outcomes for the relevant person following authorisation of a deprivation of liberty and if necessary to trigger a DoLS review. Wider independent review comes through care management oversight stemming from other guidance.

Care and treatment plans in care home settings reflected the Safeguards put in place to protect the relevant persons. They also reflected the need to consider whether an individual had the capacity to consent to aspects of care. BIAs attached few conditions to their recommendations and this may account for the lack of DoLS reviews. There had been no reviews of the authorisations within the sample. Care management reviews were carried out as expected but they did not make explicit references to the authorised deprivation.

Inspectors saw an example where the monitoring of the deprivation was the Council's responsibility (as it manages the care home) so has managing authority responsibilities as well as the care management oversight. The everyday care of the resident was good but the DoLS authorisation gave rise to little additional monitoring, for example, of the input from the relevant person's representative (RPR)[8]. The care management arrangements did not comply with the Council's own procedures, as there was no active social worker in a statutory situation. In addition, the care management review was overdue so did not comply with national guidance.

In-patient care provided by the Health Board covers a wide spectrum of conditions. In most of the case files examined, the outcomes from care and treatment were either very positive or positive. There were no specific reviews of authorised deprivations. In a number of cases, the individual returned home once treatment was completed. Where 24 hour residential care had become necessary, the appropriate placement had been arranged on discharge. In some instances, this prompted an application from the care home. Anticipating the need to lawfully deprive the relevant person of their liberty is good practice as long as consideration of a less restrictive alternative has been made.

[7] See Glossary
[8] See Glossary

3. Engaging Service Users, Patients and Carers

On behalf of all the supervisory bodies within the Consortium, the DoLS team produces letters to the individual, their carers and other interested persons named by the BIA. These are signed by designated signatories within the appropriate supervisory body. The letters explain the outcomes of assessment and state whether the BIA's recommendation has been accepted. There were errors in a few of these letters, for example information was included that only applied to someone in a care home in England, when the care home was in Wales.

The Health Board's website offers information to the public about the Mental Capacity Act and DoLS in particular as well as links to relevant government sites. Inspectors were told that the Council's website would offer similar information, but an internet search referencing the Safeguards did not find any information. The DoLS team created a detailed information leaflet, available in hard copy and electronically for the RPRs in August 2013. It includes information about how to appeal to the Court of Protection[9]. It was unclear whether RPRs have given any feedback on its effectiveness. Contact with one family suggests that the RPR in that case had not fully understood their responsibilities.

Referrals to the Independent Mental Capacity Advocate[10] (IMCA) service are generally initiated by the BIAs in the DoLS team. Referrals for the Council's area are lower than the number of DoLS applications might warrant (though not everyone is eligible). The IMCA service also covers other aspects of the Mental Capacity Act where higher volumes of referrals are made. Relations between BIAs and IMCAs are effective with good working relationships. Managing authorities also gave positive feedback where they have had contact with IMCAs, who represent the relevant person when it is required.

Two families spoke to inspectors about their experience of the Safeguards when their family members needed to be deprived of their liberty. Although they were relieved that their family member was now safe and they believed that 24 hour care was necessary, they both reflected sorrow that their family members had not been reconciled to the care home placements. Being the relevant person's representative can be an added responsibility and one family member was glad that a family friend had taken on the role. Another person's daughter had become the RPR and felt quite isolated, as there was no active social work involvement. However, as she required emotional support she did not think she needed the advice of an IMCA.

The relevant person, their representatives and families received information from the BIAs in the DoLS team about assessment and authorisations. After

[9] See Glossary
[10] See Glossary

authorisation, the RPR can ask the IMCA service for advice, though we found few that had done so. Managing authorities are required to offer support, information and advice to the relevant person and their families, but not all had carried out this responsibility fully. Where they are actively involved, care managers may also be asked for support but the level of expertise available was inconsistent. Managing authorities must ensure that their managers and staff have the necessary knowledge to fulfil their responsibilities.

Neither supervisory body had received any complaints about the operation of the DoLS process. The information leaflet makes no explicit reference to making a complaint and this omission should be remedied. Information on the internet refers to general complaints only.

There was evidence that equality and diversity had been considered in the care home placements made by the Council and the resulting care plans. In hospital settings, the patients' care and treatment needs were most likely to dictate where and how was received, but provision for individual need and circumstances, background and culture had been made. In the case files examined, inspectors were able to verify that there had been appropriate attention to equality and diversity. This was demonstrated by the use of least restrictive options in the care of some patients experiencing transient difficulties in making decisions about their care and welfare.

There was no meeting with stakeholders in this inspection as the Council and Health Board did not consider that there was an available representative group to consult.

4. Quality of Workforce

The workforce most directly engaged in delivering the Safeguards are members of the DoLS team, Section 12 doctors[11], strategic leads and signatories to authorisations in each supervisory body, 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 also need to be familiar with legal requirements including the Mental Capacity Act principles.

The DoLS team has been subject to a number of changes since it was set up, including workplace and line-management arrangements. The new health line-manager has only recently taken on the role. All team members are employed by the Health Board. There is an expectation that the BIAs within the DoLS team provide training to others when they can. We saw good feedback from training sessions given.

[11] See Glossary

The team provides much appreciated administrative support from an administrator who is a long standing member of the team, but this has been interrupted by ill health in recent months. There are currently two BIAs in the team, one of whom is the Senior Best Interests Assessor with additional duties as team co-ordinator. One is an accredited BIA and mental health nurse. The other is a well-qualified mental health nurse, who has not yet been able to undertake the BIA accreditation training. To work on both sides of the border, BIAs need to comply with different Welsh and English regulations. Due to the pressure of work, there has been little time for them to pursue their own training and development needs.

Despite their backgrounds and competence, the BIAs may encounter situations that are outside their direct experience and there is a potential for professional isolation within a small team. The failure to maintain a wider pool of BIAs increases this risk. There was originally a BIA pool containing 23 workers - nurses, social workers and AMHPs - that supplemented the work of the team. Only two practitioners from the pool have continued to offer any assistance. Most have now withdrawn because they do not feel confident to perform the role.

The DoLS team BIAs can access legal advice from a leading firm of solicitors. Team members receive additional time and support through the Senior Development and Partnership Manager who is very knowledgeable and helped to set up the original arrangements. Although she is no longer the direct line-manager, she continues to have a strategic lead and reports to the Quality and Patient Safety Committee and the Gwent Deprivation of Liberty Safeguards Consortium partners. The two signatories for authorisations in the Health Board are both very senior and experienced.

Monmouthshire County Council has no staff who are BIAs. In other councils, where there are BIAs within Adult Services care management teams, they act as an expert resource and there is evidence that this raises everyone's awareness of the Mental Capacity Act and DoLS. The DoLS team offer expert advice but are not as readily available for informal discussion in the way that BIAs within care management teams are.

There is no plan to re-instate the BIA pool. The Council does not consider that there is sufficient capacity to release staff to train as BIAs and then carry out the work. However, some care managers interviewed during the inspection demonstrated a good understanding of the Mental Capacity Act as a whole and of the Safeguards, including third party referrals. They said they would like to take on the BIA role if the current criterion had not tied the role to qualifying as an AMHP first. There is a shortage of AMHPs as many of the Council's social workers are reluctant to take on the role reluctance to take on the role outside of the CMHT's. Inspectors were told that there is a tendency for social workers to ask AMHPs to take on roles such as assessing mental capacity, as if this were a specialist task. This apparent contradiction needs to be resolved. Understanding the Mental Capacity Act is a mainstream activity which should underpin the knowledge and skills of all Adult Services social workers and care managers'.

In the Health Board, inspectors found a wide range of knowledge and understanding among both managers and staff. This varied from practitioners who are very competent and knowledgeable to others who were frank about their lack of confidence and understanding. The use of the Mental Capacity Act and DoLS is not embedded in their day to day practice. As a result assessment of mental capacity and ability to consent to potential deprivations of liberty may not routinely take place.

Training has been given a high priority over the years, with DoLS team members providing much of the input. Initial awareness and then up-date training to provider staff in care homes and on wards was well appreciated, as evidenced by written feedback. However, as the DoLS team has become increasingly focussed on meeting the demand for BIA assessments, the amount of training has decreased significantly. Health staff indicated that they do not find e-learning to be effective, particularly as there is no practical aspect associated with the theoretical content. Care home providers contacted during the inspection appreciated the training given in the past and have also commissioned their own training from other sources. Social workers and care managers from the Council indicated that they would welcome further training on the MCA and the Supreme Court judgment[12]. Staff spoken to in the Council's own care home also recognised that further training was needed, despite the registered manager's expertise.

5. Leadership and governance

When the Safeguards were implemented in 2009, governance and management arrangements for the DoLS team were well thought out. There was a clear governance framework, with clarity about each Consortium partner's role. Each supervisory body designated signatories to authorisations. Policies and procedures were put in place for the DoLS team, managing authorities and supervisory bodies. These were reviewed in 2011. They now require updating to reflect changes in case law including the Supreme Court judgement.

The DoLS team has routinely provided regular performance information. The Health Board has provided summary annual reports to its Consortium partners. The most recent annual report, dated August 2013 recognised considerable workforce pressures on the DoLS team from the imbalance of demand against available resources. It also recognised the difficulty in engaging BIAs from outside of the team. This led to agreement to recruit a further BIA as well as to amending the team leader role to that of Senior Best Interests Assessor. Nevertheless, from September 2013 to March 2014, one BIA covered nearly all of the work until the Senior Best Interests Assessor joined the team. A vacancy remained in the team at the time of the

[12] See Glossary

inspection. The length of time from making the decisions in August 2013 to implementing change was unacceptably long.

The DoLS team is recognised as an important resource for all six organisations. This has been demonstrated by additional funding provided to recruit further BIAs to the team to meet the increased demand from the Supreme Court judgment. At the time of the inspection, the active BIAs were not able to meet the legislation's timetables for assessment. The Senior Best Interests Assessor highlighted over-due assessments to the supervisory bodies in the Consortium through weekly e-mails, as they remain liable for any consequences of delay. The Council was aware of this but had not made any firm plans to deal with the issues at the time of the inspection but options were being considered.

The partnership input to joint working within the Consortium was very robust at the outset, but then became less active. However, since the Supreme Court judgment, prompted by proactive briefings from the Health Board managers, its members have been evaluating the potential increase in demand and the risks of failing to meet them. They were working on an action plan to resolve the difficulties at the time of the inspection.

The Health Board has continued to receive regular reports regarding the Safeguards. The most recent was in April of this year proactively appraising very senior managers of potential risks that might stem from failing to take full account of their responsibilities. It has been proactive in ensuring that its managing authorities (senior ward managers) have received notification of the Supreme Court judgement and its implications. It has also sent briefings to other organisations potentially affected by the ruling, such as supported accommodation providers, where the Safeguards cannot apply. The Council has not routinely reported the outcomes of the annual reports to its Scrutiny committee, although it is now briefing its elected members on the potential resource implications likely to arise from the Supreme Court ruling. The Council needs to consider its structures further to ensure no conflicts of interest exist. The Director of Social Services' Annual Statutory report has not given information on DoLS.

The Health Board and the Council have both experienced considerable changes to their respective structures since 2009. In the Council, some roles have become intermeshed. The lead for provider services (who is the Responsible Individual under care standards legislation) is also the head of commissioning. This person reports to the Head of Adult Services who is one of two signatories for authorisations for the supervisory body. Although the legislation and guidance makes clear that single body can act in both capacities, it also recognises that there is 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 its structures to ensure no conflicts of interest exist.

When the Safeguards were implemented, there were five commissioning local health boards (supervisory bodies) relating to a large provider trust (managing

authority). Aneurin Bevan University Health Board has since held both functions, and it has achieved the required separation.

The potential impact of the Safeguards upon care home contracts has only recently been recognised in social services commissioning. The quality assurance requirements required by the Council do not currently reference the Mental Capacity Act or DoLS although the current service specification for residential care, nursing care and continuing health care is being reviewed. In future it will require staff in provider organisations to receive mandatory training in the MCA and DoLS. The implications of the recent judgment for supported accommodation and other social care provision are being evaluated. Better connections are being forged between contract monitoring, care management reviews and the Safeguards. Health contract monitoring where there is nursing care in care homes has been more pro-active although there is no evidence that it feeds into social care contracts as yet.

A small number of staff have worked very hard to deliver the DoLS service satisfactorily to vulnerable people and have largely succeeded. However, the increased demand has demonstrated the fragility of the DoLS team model. The Council needs to works with its partners in the Gwent Consortium to act on their statutory responsibilities as supervisory bodies and to support the DoLS team to ensure the quality and sustainability of the service.

Recommendations

1. The Council and the Health Board as part of the Consortium should ensure that the agreed numbers of BIAs are achieved rapidly to meet the requirements of the legislation.

2. When reviewing BIA capacity in the light of the Supreme Court judgment, the Council should reconsider its decision not to locate some BIA function in its Adult Service care management teams. It must ensure that knowledge of the Mental Capacity Act and DoLS is embedded in all care management roles. Where there are authorised deprivations in place, care management reviews should reflect consideration of their outcome and effectiveness.

3. The Council and the Health Board as part of the Consortium should review their engagement with the relevant person, their families and informal 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. The Council should work with the DoLS team to ensure that its citizens benefit from the IMCA service where appropriate

4. The Council and the Health Board as part of the Consortium should develop robust quality assurance mechanisms urgently, so that assessments and authorisations comply with legislation, guidance and case law. All partners in the Consortium should take responsibility for quality assurance alongside the DoLS team.

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

6. The Council should ensure that it reports information on the Safeguards to senior managers and elected members regularly in accordance with the Consortium's terms of reference.

7. The Council and the Health Board as part of the Consortium should discuss whether its Annual Reports should also be considered in the Joint Safeguarding Board.

8. The Council and the Health Board as part of the Consortium should 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. The Consortium should audit the effectiveness of all such training.