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

Powys County Council
Powys Teaching Health Board

6 – 8 May 2014

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

POWYS COUNTY COUNCIL
POWYS TEACHING HEALTH BOARD
6th – 8th 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 Council and Health Board. 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

Powys County Council and Powys Teaching Health Board share the same geographical boundaries in mid-Wales. They work very closely together for the same population and are working towards one strategic plan. Staff and managers in both organisations work co-operatively as two supervisory bodies[1] to implement the Safeguards, although they maintain accountability for their own decisions.

The Council does not directly provide care homes so has no managing authority[2] functions. The Health Board provides in-patient care in Community Hospitals which are managing authorities. The Health Board also has partnerships with other Welsh health boards that provide some aspects of in-patient care both within Powys and in their own area as there are no full District General Hospital facilities within its boundaries.

The long eastern border of Powys is part of the boundary between Wales and England so that staff from both organisations regularly work with colleagues in English managing authorities. The operation of supervisory body responsibilities in healthcare is different in England and Wales. Where Powys Teaching Health Board commissions care and treatment in a hospital in England, the Health Board acts as a supervisory body even though the managing authority is outside its geographical boundaries. This is also true of the local authority as a Supervisory Body.

In 2013-14 a total of 22 applications were received by the Council and 8 by the Health Board. In 2012-13 [3], 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 received the fourth highest level of applications from care homes, while the Health Board received the third highest level from healthcare settings.

1. Quality of Applications & Assessment

Despite higher numbers of applications in comparison with other supervisory bodies, more could be expected from the range of settings in which a deprivation may take place. The same care homes have tended to make applications over the years. Often applications from care homes were prompted by the multi-disciplinary teams arranging hospital discharges and making plans to place the relevant person[4] in 24 hour care because returning to their own home was no longer sustainable. Hospitals in England send the

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

greater proportion of the healthcare applications. There were no third party applications in the year.

All managing authorities send their applications to the DoLS administrator who processes them for both supervisory bodies. The quality of applications varied in the sample examined. Some were well expressed with clarity about the areas of deprivation. Others were more vague. One application from a hospital in England sought, incorrectly, to use DoLS when another aspect of the Mental Capacity Act was relevant. 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. We were told that this is followed up by the DoLS lead officers, but the information gained had not been recorded.

Wherever Powys residents receive health or social care, the Best Interests Assessors (BIAs)[5] and DoLS lead officers work with managers and staff for the managing authority. BIAs need to comply with the different regulations in England and Wales so they can work in both countries. On several occasions they were able to help the managing authority find a better, less restrictive form of care rather than recommend a deprivation.

The applications for some relevant persons came after a period of detention under the Mental Health Act, 1983[6]. Generally these were well founded indicating that the social and healthcare practitioners understood the different powers and uses of both pieces of legislation. On one occasion the family was very keen to have the Safeguards used so that the individual could remain in a care home. They saw this as the least restrictive setting and practitioners respected this, even though the Mental Health Act had to be used very soon after the deprivation was authorised.

The assessments seen in the samples were generally well written and clear with appropriate content. They demonstrated good information gathering and decision making. Most assessments were undertaken within the required time limits, although there was one example in a health care setting where the BIA assessment was undertaken but a report never delivered. This was not picked up. There were some errors on assessment forms, including failure to delete some sections of the forms. More attention needs to be given to quality assurance of the documentation. Inaccuracy in some details, such as correct dates, could invalidate authorisations and leave the council and the health board open to censure. There is already a checklist/flowchart in use which is intended to aid assessors and to minimise error. However, this checklist had not highlighted the errors found by the inspectors. The resources available for the assessment and quality assurance processes are limited by the time available to the assessors, particularly the BIAs. All the BIAs have to balance their work with their other casework responsibilities.

[5] See Glossary
[6] See Glossary

The two authorities have set up a joint panel which discusses any recommendations for authorisation of deprivations of liberty. Members are drawn from practitioners and managers in health and social care with understanding of DoLS, with one panel member from the relevant supervisory body accountable for accepting and signing each authorisation. This panel offers opportunities for quality assurance of the process that should be extended.

2. Quality of Outcomes

Inspectors found variability between the understanding of managing authorities in social and health care settings within Powys. In social care potential deprivations were more likely to be identified if the relevant person had been in hospital prior to admission to a care home. This occurred regardless of whether an authorised deprivation had been in place in hospital. Urgent authorisations are put in place when necessary. Most managing authorities contacted in Powys healthcare settings indicated that they were not confident of identifying a deprivation of liberty. If deprivations of liberty are not identified, a less restrictive alternative cannot be considered, neither can the deprivation be legally sanctioned and appropriate checks put in place. However, the case files examined showed that applications had been made, although only one deprivation of liberty was authorised in a Powys hospital in 2013/14.

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, but care management reviews had occurred in a timely way where required by guidance.

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.

Good practice

Powys County Council

A care manager had skilfully employed Mental Health Act/Mental Health Measure requirements to monitor the relevant person's progress in the care home and to check that the deprivation continued to be appropriate. This ensured that care was provided to the individual in ways that delivered good outcomes.

By contrast, in another care home where the relevant person was paying for their own care, there was no mechanism for care management reviews. The managing authority had not called for a review of the Safeguards. They did not inform the Council when the individual died, even though the authorisation was still in place. Consideration should be given to the potential vulnerability of a relevant person with an authorised deprivation where care is given without regular independent review. The Council purchases care from a significant number of providers inside and outside of its county and country boundaries. It needs to build a clearer connection between social care review and contract monitoring processes which include monitoring the impact of any authorised deprivation of liberty.

3. Engaging Service Users, Patients and Carers

BIAs and other assessors make efforts to engage with relevant persons, their representatives and families. The DoLS lead officers also offer advice and information. The Council and the Health Board write to those named by the BIA explaining the outcomes of assessment and whether the BIA's recommendation has been accepted. There was evidence that this had been carried out in a satisfactory manner. They have created information leaflets for the relevant person, their representative and a guide for family, friends and unpaid carers. The leaflets can be made available in Welsh but this is only provided on request. This does not comply with the requirements of the Welsh Language legislation. The two organisations have sought feedback on the leaflets which indicated that more clarity was needed. So far, no revisions have been made.

After authorisation, the managing authorities are required to offer support, information and advice. Care managers may also be asked for support where they are actively involved. In both cases, the level of expertise available was inconsistent. Managing authorities must ensure that their staff have the necessary knowledge to fulfil their responsibilities.

Inspectors spoke to family members who were also the relevant person's representative. They also spoke to Independent Mental Capacity Advocates[7] (IMCAs) supporting the relevant person where there are no family or friends. Relevant person's representatives[8] had been appointed in all the cases examined. IMCAs may also give advice to family members about their role as representative if the family member wishes. The families contacted were both in the north of the county; they had not requested the services of an IMCA to provide advice.

Two separate organisations manage the IMCA service in north and south Powys. Referral patterns to IMCAs are markedly different in these two areas.

[7] See Glossary
[8] See Glossary

Regular referrals and close working was reported in the south, with less frequent referrals to the service and less common ground reported in the north. Discussion with bodies that provide general advocacy suggested that families were sometimes uncertain which source of advocacy they should seek. The Health Board as the commissioners of IMCA services and the Council who commission other relevant third sector services should jointly explore these issues and develop a more consistent approach across the county so that citizens/patients receive equal access to effective advocacy.

Neither supervisory body had received any complaints about the operation of the DoLS process. None of the information leaflets make explicit reference to making a complaint and this omission should be remedied. There was evidence that equality and diversity had been considered in social care placements and the resulting care plans. In hospital settings, the patients' treatment needs were most likely to dictate where and how they received care 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.

4. Quality of Workforce

The workforce most directly engaged in DoLS comprises the two lead officers, administrative support, the assessors including BIAs and Section 12 doctors[9], 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.

Both lead officers for DoLS are knowledgeable and competent. On behalf of the two supervisory bodies, they encourage service providers (managing authorities) to seek advice on the Safeguards. Some awareness training has been provided to the relevant Powys-wide workforce through the Social Care Workforce Development Programme[10] and continues to be offered. Some care providers also provide their own staff training. Despite this, inspectors received feedback from staff in hospitals and care home managing authorities that they did not feel confident in their understanding of DoLS. There were different perspectives on whether sufficient training had been offered or whether staff had made best use of what was available, particularly in hospital settings. All managing authorities reported difficulties in releasing staff for the training, which is not mandatory. The E-learning programmes offered to health staff were not considered to be effective.

[9] See Glossary

[10] 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.

Specific training has been made available to BIAs, which led to the accreditation of 7 staff in social care and 3 in health. (This reflects the proportion of applications from care homes.) This training has been at least annual. A wider range of assessors including Section 12 doctors have also received legal updates. The contract monitoring officers have been highlighted as a group who should receive relevant training, so as to increase their awareness of the impact of authorised (legal) and unauthorised (illegal) deprivations of liberty in independent care homes.

BIAs reported feeling confident in their practice having found their training to be effective. They are supported by a joint Best Interests Assessors' group which meets quarterly. They consider their workloads to be demanding, because of the depth of assessment required and the timetable for the completion of assessments. The work has to be met alongside their other responsibilities. They are well supported by the DoLS lead officers. However no formal one to one supervision arrangements are in place over and above what they receive in respect of other responsibilities in their substantive posts. There is evidence that BIAs within a team raise everyone's awareness of MCA and DoLS and that they act as an expert resource.

BIAs are also able to call on legal advice. In the Council, this is provided by in-house solicitors who make any applications to the Court of Protection. The solicitors are linked into the Deprivation of Liberty oversight group and are part of a group briefing senior managers and members on the implications of recent legal judgments.

The Supreme Court Judgment[11] (published on 28th March 2014) clarified the definition of deprivation of liberty and is likely to significantly increase the number of applications from care homes. The ruling also indicates that potential deprivations of liberty may occur outside care homes and hospitals, where the DoLS procedures are not applicable. This means that care managers working with people in supported accommodation will need to ask their legal advisers to make applications to the Court of Protection[12], which will be a new area of work. The Council and the Health Board are working on an Action Plan to evaluate the potential increase in demand and to respond appropriately.

Access to IMCAs was not highlighted as a problem by BIAs, whereas IMCAs in the north thought that there should be higher rates of referral to them, based on their understanding of the number of eligible people.

5. Leadership and governance

The governance arrangements for DoLS are unclear with little routine performance examination beyond that required for monitoring by CSSIW and

[11] See Glossary
[12] See Glossary

HIW. There are currently no written policies and procedures. Analysis of performance and effectiveness has been limited to a joint, informal audit of the DoLS processes. This recognised that there are insufficient resources to meet existing demand and that the existing service structure is fragile. More positively, the lead officers for DoLS and the BIAs have worked closely together on operational issues. There is also a longstanding operational Deprivation of Liberty oversight group which includes an IMCA. This has considered good practice, process and areas for development.

There are two lead officers for DoLS, generally referred to as DoLS co-ordinators, who work closely together although they are not co-located and are on different grades. They have significant other duties outside DoLS. The social services lead officer is over-burdened – she is also a BIA and an Approved Mental Health Professional[13] (AMHP). On occasions she had been the Council's signatory for authorisations. The lead officer in the Health Board has a number of strategic responsibilities including staff management so that the DoLS responsibilities form a small part of his remit. The plans to strengthen this structure and increase resources were made some months ago, but there has been little progress in implementing change.

Reporting arrangements are different in the Health Board and the Council. In Powys Country Council reporting upwards has been contained within Adult Services, rather than across senior managers and to the Director. The Director of Social Services Annual Statutory report has not given information on DoLS. There are plans to alert elected members to likely resource implications and the risks of failing to meet the statutory requirements made by the Safeguards. Management arrangements in social services have been through several stages since the Safeguards were implemented and the Council are still strengthening them. There is a new head of Adult Services, who is very aware of the statutory requirements of the Safeguards, but has also to take forward other initiatives. This includes an over-all re-focussing of the management structure in the services she manages. The manager currently directly responsible for DoLS is holding the responsibility temporarily.

Powys Teaching Health Board has an upward reporting structure with responsibility being held by the Board Director and devolved to identified staff members.

Although there is a joint Powys Safeguarding Board, there has yet to be any report on DoLS. An action plan was made available to inspectors after the inspection had ended, but is still an overview rather than a detailed implementation plan.

In social services the requirements of the Safeguards on managing authorities in care homes has not hitherto been recognised as part of commissioning. The quality assurance requirements required by the Council do not currently reference the Mental Capacity Act or the Safeguards. There is little

[13] See Glossary

connection between contract monitoring, care management reviews and DoLS. Health contract monitoring where there is nursing care in care homes has been more pro-active and could be used more effectively in social care contract monitoring. There have been recent changes in line-management bringing plans to strengthen both operational contracting and strategic commissioning to incorporate the requirements of the Safeguards. 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.

Staff have worked hard to deliver the DoLS service satisfactorily to vulnerable people and have largely succeeded, with partnership working between health and social services a real strength. Both organisations now need to give their statutory responsibilities more priority and take strategic action to ensure the quality and sustainability of the service.

Recommendations

1. The Council and Health Board should ensure that the DoLS service moves to a sustainable footing with clear management accountability and governance arrangements. They should implement the existing action plan promptly.

2. The Council and the Health Board should develop robust quality assurance mechanisms urgently, so that assessments and authorisations comply with legislation, guidance and case law.

3. When reviewing the implications of the Supreme Court judgment, the Council should ensure that knowledge of DoLS and the Mental Capacity Act is embedded in all staff with care management and contract monitoring responsibilities in adult services.

4. The Council and the Health Board should ensure that improvements to performance management and monitoring are given priority. This includes regular reporting to senior managers and to the Joint Safeguarding Board or similar partnership body.

5. 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.

6. The Health Board and the Council should examine the differences in levels of referrals to the Independent Mental Capacity Advocate services in the North and South and develop a more consistent approach across the county so that citizens/patients receive equal access to effective advocacy.

7. 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. They should audit the effectiveness of training.