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

Rhondda Cynon Taf County Borough Council Cwm Taf University Health Board

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

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
and
CWM TAF 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 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 review 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 LAs and LHBs.
- 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

Rhondda Cynon Taf County Borough Council is the larger of two local authorities in the area of Cwm Taf University Health Board.

In preparation for the introduction of the deprivation of liberty safeguards in 2009, the then two local health boards (Merthyr Tydfil and Rhondda-Cynon-Taff) and Cwm Taf NHS Trust and two local authorities (Merthyr Tydfil CBC and Rhondda Cynon Taf CBC) agreed to pool budgets, to appoint a single professional co-ordinator and to establish a common pool of Best Interests Assessors (BIAs), with Rhondda Cynon Taf CBC as the lead authority. This arrangement has continued and remains in operation today. The local authority and current health board are each both supervisory bodies and managing authorities for the purposes of the deprivation of liberty safeguards.

In the year 2012-13, the rate of DoLS applications for authorisations as a proportion of population in Rhondda Cynon Taf CBC was the second highest of all local authorities and in Cwm Taf UHB the highest of all health boards.[1] In 2013-14 there were 38 applications for Rhondda Cynon Taf CBC and 40 for Cwm Taf UHB[2].

Inspectors spent three days in the local area in May 2014. They examined a sample of case files and other relevant documents, met people who were subject to the safeguards and people directly responsible for their care, and held a range of interviews and meetings with relevant staff from the local authority and health board, care home managers, independent mental capacity advocates, and representatives of voluntary organisations. The inspection was usefully informed by a review of the service model and operational arrangements for the deprivation of liberty safeguards produced in September 2013 by the Adult Safeguarding Service Manager for Rhondda Cynon Taf CBC.

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[1] Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care. CSSIW & HIW, February 2014

[2] Figures provided to CSSIW.

1. Quality of Applications & Assessment

With few exceptions, applications for authorisations for deprivations of liberty appear appropriate and timely. Managers in care settings were aware when authorisations were needed[3] and were familiar with the process for seeking them; they knew the DoLS co-ordinator, to whom they turned frequently for advice. This was evident as many SA1 forms that were submitted were not always adequate and the DoLS co-ordinator was required to provide guidance. In all hospital cases seen by inspectors there was prompt identification of the need for a DoLS application. However, it was acknowledged that within the Health Board the number of applications was probably not an accurate reflection of the actual need for DoLs authorisations. This is because there remains a large proportion of Health Board staff who have either received minimal or no training and a number of staff who have not received further training since the inception of DoLS in 2009.

There were, however, still cases in which deprivations of liberty were happening or continuing without authorisation, mainly because of delays in processing applications. There were a number of instances where Managing Authorities had to extend urgent authorisations due to problems with assessments being carried out within the statutory timeframe.

Such delays constitute a major problem. They can leave a vulnerable person unprotected by proper assessment and authorisation and may leave the supervisory body open to legal challenge, with consequent reputational and financial risk. In the six months from April to September 2013, required timescales were not met in 63% of the cases, mainly because of difficulty in finding a BIA[4] able to respond promptly. The problem is exacerbated by the frequent use of short – sometimes very short – authorisations, which place more demand on the system and leave less time to plan the deployment of resources. To counter this problem, the supervisory bodies have made BIAs readily available by introducing a rota; this has brought improvement but has not completely eliminated the problem.

The quality of assessments is high. All elements of the process are completed as required by the Code of Practice. Individuals' needs and risks are conscientiously analysed in the context of their particular environment. The professional knowledge of assessors is supplemented by advice and guidance from the DoLS co-ordinator, and by specialist assessment (for example by a neuro-psychiatrist) when required. Standard forms and letters are used in compliance with the Code of Practice.

[3] The findings of this report are based on guidance and good practice as generally understood at the period under review. Recent Supreme Court judgments (P v Cheshire West and Chester Council and P and Q v Surrey County Council) redefine what constitutes a deprivation of liberty.
[4] See Glossary.

In most cases seen by inspectors there was no need for referral to the Court of Protection. In one case, a possible need for referral to the Court was overlooked; in another, a referral was made appropriately.

2. Quality of Outcomes

The quality of outcomes was generally good. BIAs make conscientious efforts to seek constructive solutions and least restrictive outcomes. The way in which the DoLS processes have been introduced and led locally – with extensive training and other means of raising awareness –has promoted such an approach more generally among managing authorities and other relevant staff. Ward staff sought to meet the needs of patients in the least restrictive ways. Transfers between hospital wards and between hospitals and care homes were well managed.

Through recommending conditions of authorisations, BIAs have encouraged assessors and care managers and service commissioners to find alternative placements or to provide extra resources to allow a lesser degree of restriction or to enhance the quality of life. Short periods of authorisation are used, not always appropriately, to create more urgency. Some cases raise questions as to the appropriate dividing line between the respective roles of BIAs and assessment and care management staff. Conditions set by the supervisory body, which should be binding, are not always met. The combination of short periods of authorisation and conditions not being met were especially problematic in hospital settings as some individuals were required to have repeat applications which was a strain on capacity. But there is no doubting the intention to observe the five principles of the Mental Capacity Act 2005 and inspectors saw impressive examples of this in individual cases.

Good practice

During the many months that the patient was accommodated within the hospital, records provided evidence of the regular review of the patient's mental capacity with regard to their long term care and support arrangements. A number of standard authorisations were requested and granted during that time. The patient was eventually transferred to a care home and remained subject to a standard (but new) authorisation within that facility. The standard authorisation was lifted at the point when the patient chose to leave the care home in favour of living in the community. The patient was subsequently supported to secure his own accommodation in a different locality.. Whilst there were no follow-up appointments needed in respect of neurological services, the patient remained supported by the locality care management team following discharge.

The use of short periods of authorisation means that there are few formal reviews. In practice, many cases are kept under informal review through frequent liaison between the DoLS co-ordinator and staff from managing authorities and assessment and care management teams.

3. Engaging Service Users, Patients and Carers

DoLS staff and BIAs make efforts to engage service users, patients and carers, as do ward staff – this is evidenced in patient records. Written information is routinely provided, usually (and necessarily) supplemented by verbal explanations. Assessments show clear attempts to take into account the wishes and feelings of those involved. Information leaflets for have been produced by the DoLS partnership consisting of The Councils and the Cwm Taf UHB for patients, relatives and carers. Hospital staff we spoke with knew where to find these on the intranet site.

Relevant person's representatives[5] were appointed in all cases seen by inspectors. Independent mental capacity advocates (IMCAs)[6] are provided for cases in which no relevant person's representative is available or to support the relevant person's representative. IMCAs interviewed by inspectors reported that their role was respected by the supervisory bodies.

In cases seen by inspectors, there was evidence that BIAs and managing authority staff had responded appropriately to the wishes and feelings of the individuals concerned, and made efforts to tailor service provision to individual need and circumstances, background and culture.

4. Quality of Workforce

The workforce most directly engaged in DoLS comprises the co-ordinator and administrative support and the BIAs, together with their respective managers, the doctors who undertake assessments, and the IMCAs. In addition, staff in managing authority establishments (hospitals and care homes) and in social services assessment and care management teams also need to be familiar with the legal requirements and principles of good practice.

The co-ordinator has become a specialist in DoLS, well known as such in the local area and beyond. He provides a central source of advice and guidance to others. BIAs are drawn from staff (social workers and nurses) of the three supervisory bodies and carry out the work alongside their existing duties; they are all trained[7] and receive continuing professional support and development, organised largely by the co-ordinator. The doctors are local practitioners

[5] See Glossary.
[6] See Glossary.
[7] to the standard required by English, but not Welsh, regulations.

approved under Section 12(2) of the Mental Health Act 1983. IMCA services are provided by the south-east Wales branch of IMCA Wales, which is a part of Mental Health Matters (a registered charity).

The retention and availability of BIAs has proved problematic. At the time of the internal review (September 2013), 38 had been trained and 5 were undergoing training, but only 17 were currently practising. The workload of their substantive posts had made it difficult for them to find time promptly to respond to requests to undertake DoLS work, and there has been no standard system to relieve them of or to reschedule other duties. The recently introduced rota system, by which two assessors are on standby each week for DoLS work, has alleviated the problem for the assessors and their line managers by making the work demands more predictable, but there still appear to be problems of overall capacity – in numbers and distribution (among the three supervisory bodies) and in time set aside for DoLS work.

Both medical assessors and IMCAs have been generally available as required. The doctors are paid a fee for their work. The IMCAs are funded through a contract between the health board and Mental Health Matters.

Training for care home managers has been provided through the Social Care Workforce Development Programme[8], supplemented by advice and guidance readily available from the DoLS co-ordinator. Training for health service staff is provided as part of training on protection of vulnerable adults, which is compulsory, but has not yet covered all relevant staff. The awareness levels of staff in care homes and hospital wards is variable: it is highest in those settings where the safeguards have been most frequently used. Health Board staff stated that the NHS core skills (which are required of the workforce) do not currently include skills with relating to MCA and DoLS. It was felt this meant DoLS had a lower profile across the Health Board than would otherwise be the case if it were included as a core skill.

5. Leadership and governance

The formal partnership arrangements between the (then four, now three) supervisory bodies was set up in time for the introduction of DoLS in April 2009. It was underpinned by a Memorandum of Understanding establishing the shared arrangements and designated Rhondda Cynon Taf CBC as the lead authority, to hold the budget, to host the co-ordinator post and administrative support, to receive and manage all DoLS requests from managing authorities, and to commission and collate assessments on behalf of the supervisory bodies, for decision on authorisation by the respective individual supervisory body. It was overseen by a steering group, comprising senior representatives from the constituent bodies. The constituent bodies have an established pattern of effective partnership working in other areas of health and social services and in more general public service provision.

[8] Funded by the Welsh Government.

It is clear, however, that some aspects of governance require further attention. There are evident strains within the system. The operation of the service has become too dependent on the role of DoLS co-ordinator. While it has gained strength in its proper independence of assessment and judgment, it is not sufficiently well integrated vertically or horizontally into the mainstream work of the supervisory bodies: in particular the recruitment, professional support and workload management of BIAs has relied too much on the interest and goodwill of individual practitioners rather than being formally managed; it is also not clear how far the operation of DoLS has been set within the context of a more comprehensive understanding of approach to dealing with mental capacity in health settings and in social services assessment and care management teams. The budget for the central co-ordination function requires review, as do the respective contributions in kind (chiefly the provision of BIAs) in relation to the demands made upon the system (in the form of requests for authorisations). The steering group had met every six months between March 2013 and March 2014, but there had been no regular reporting to board or cabinet/council level. The implications of the recent Supreme Court judgments may also require significant changes.

These matters have been recognised by the supervisory bodies and some actions have already been initiated. They are addressed in the internal review produced in September 2013, which contained recommendations for resolving problems and making improvements. Discussions have begun within and between the constituent bodies on issues of budgets and resources, on placing the DoLS services under the aegis of the Adult Safeguarding Board and clarifying the reporting arrangements. A formal paper on DoLS was noted by the health board in May 2014. The recommendations of this report largely underline those matters already under consideration.

Both reviewed organisations carry managing authority as well as supervisory body responsibilities. In Rhondda Cynon Taf CBC the reporting line for the supervisory body functions is through the Adult Safeguarding Service Manager to the Service Director for Community Care, and for the managing authority functions through the Residential Services Manager and Head of Service to the Service Director for Direct Services, Housing & Business Support. The Health Board report on DoLS arrangements and activity through the Safeguarding adults group which reports to the Executive Safeguarding Group and then to the Clinical Governance Group, which is a standing Committee of the Board. In its MA role, DoLS has been placed within Adult Safeguarding and Patient Safety. There is a clinical nurse specialist who provides advice and support to ward staff in relation to DoLS.

Recommendations

1. The two county borough councils and the local health board ("the partners") should agree and implement effective future governance arrangements for the DoLS service.

2. These arrangements should include:
    - mechanisms for agreeing and monitoring the shared arrangements and dedicated resources from year to year;
    - clear reporting arrangements to board and cabinet/Council level (and to and through the Adult Safeguarding Board as may be decided).

3. The partners, in consultation with each other, should review how they provide BIAs, with a view to better workload management of DoLS duties alongside other responsibilities which the assessors may hold.

4. The partners must ensure that assessments and authorisations are carried out within prescribed timescales.

5. BIAs, assisted by the DoLS co-ordinator and the adult safeguarding service manager of the lead authority, in consultation with others as appropriate, should review aspects of practice, in particular the lengths of authorisations sought, recommended and granted; and the use of reviews within the period of an authorisation.

6. The partners should consider the broader approach to mental capacity within their respective organisations, and how well DoLS practice is integrated with this and helps to inform it.

   All the above should be carried out in the light of changes in expectations and practice consequent on recent judgments of the Supreme Court.