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

April – May 2014

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DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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Print ISBN 978 1 4734 2418 0
Digital ISBN 978 1 4734 2416 6

WG23472

The National Review

The Mental Capacity Act 2005[1] (MCA 2005) provides the statutory framework for acting and making decisions on behalf of people who lack the capacity to make decisions for themselves. The Deprivation of Liberty Safeguards[2] (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.

The national review was carried out as part of Care and Social Services Inspectorate Wales (CSSIW) and Healthcare Inspectorate Wales (HIW) monitoring of DoLS in Wales. CSSIW and HIW made a commitment to undertake further work during 2013/14 to examine the application and effectiveness of DoLS practice following the publication of the third annual monitoring report, 2011/12.

The objectives were as follows:

- To establish whether "the Safeguards" 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 to determine whether the guidance should be revised and updated.
- To investigate what contributes to inconsistencies in the use of DoLS across Welsh Councils and Local Health Boards (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.

[1] See Glossary
[2] See Glossary

What was working well

- The Supervisory Bodies[3] DoLS co-ordinators were the linchpin of the system and it was often their personal commitment that had the biggest impact on the quality and quantity of applications. This was true both in LHBs and councils, and accessibility, approachability and consistency of advice were essential qualities.

- The Best Interest Assessors[4] (BIAs) are a skilled and valuable resource, and across Wales there are a range of experienced professionals undertaking this role. They have a significant impact on influencing the practice of their colleagues as they act as an internal resource/champion within their teams and service areas. In this way they make a great contribution to the embedding of the five principles of the MCA into the working culture and practice of health and social teams.

- There were some effective health and social care partnership arrangements in place for DoLS, which made the best use of resources, such as BIAs and supported a shared multi-disciplinary approach to some very complex cases.

- Several authorities and partnerships have in place a DoLS good practice forum which meets periodically in order to share learning from complex cases and consider emergent case law. It would be beneficial to consider how to engage Managing Authorities in this or a similar forum.

- There were some very good examples of localised policies and procedures in place; including examples of exemplar forms which illustrated what level of detail was required and provided help with language and terminology.

- The governance arrangements seen in the LHBs were generally clear and robust, with identified DoLS signatories and a clear separation between Supervisory Body and Managing Authority functions.

- Where Safeguards were in place, they had contributed to supporting people in very challenging circumstances and were particularly effective where there were bespoke conditions aimed at working towards reducing/removing the deprivation.

[3] See Glossary
[4] See Glossary

What needed to improve

The use of conditions[5] was very variable and some areas rarely used them, which meant that a deprivation had been authorised, but not enough was being done to seek a less restrictive solution for the Relevant Person. Equally, the very short duration of some authorisations had meant that the Relevant Person's situation had not changed before further authorisations were due.

Recommendations

1. **Supervisory Bodies should audit their current practice to ensure that conditions are used where necessary and that these are focused on improving outcomes for the Relevant Person, including reducing or removing the deprivation.**

2. **Supervisory Bodies should ensure that the duration of the DoLS authorisations are compatible with working towards the least restrictive option.**

The Managing Authorities [6], especially but not exclusively care homes, were not always aware of their responsibilities under DoLS and relied heavily on the Supervisory Bodies to prompt and manage the process. This meant that the quality and quantity of the applications was varied even between health and social care settings where the needs of the people were very similar. Some Managing Authorities thought that making a DoLS application would reflect badly on their organisation, and did not understand that they demonstrate a proactive and preventative approach to supporting people who do not have mental capacity to make decisions about their care and support arrangements.

Information for the public was available but not always in an accessible format. It was suggested by carers and other stakeholders interviewed during the review that there should be "easy read" versions of the Code of Practice available and that it should be circulated more widely, in particular to the carers' organisations.

Recommendations:

3. **Councils and LHBs should ensure that the MCA and DoLS are reflected in their contracts, service specifications and monitoring arrangements with Managing Authorities, including requirements for mandatory training and how the principles of the MCA are embedded in the day-to-day care and support arrangements.**

4. **Supervisory Bodies should develop robust quality assurance and reporting mechanisms to ensure that applications, assessments and authorisations comply with legislation, guidance and case law.**

5. **Supervisory Bodies and Managing Authorities should ensure that information about DoLS and the MCA is readily available in a range of formats.**

The training and skills development for staff involved in the delivery of the MCA and DoLS was very fragmented. Managing Authorities need to have reliable access to training and ongoing professional support which is focused on their particular role and responsibilities. For example, DoLS training was not always mandatory and was sometimes combined with

[5] See Glossary
[6] See Glossary

safeguarding into a single session. This can cause confusion and may contribute to the variability in the identification of deprivations by Managing Authorities which was very concerning.

The recruitment of BIAs has been approached very differently across Wales and not all Supervisory Bodies had access to sufficient numbers or the necessary range of experience and professional skills. The BIA role was perceived as an "add on" and BIAs often had to negotiate with their manager to be released to undertake the assessments.

The training for BIAs is also accessed in different ways across the Supervisory Bodies in Wales. This means that some courses being accessed are not accredited and other Supervisory Bodies are accessing the courses that are still accredited in England.

Recommendations:

6. **The Supervisory Bodies should have in place a workforce development strategy to ensure that they are able to meet the requirements of the MCA, DoLS legislation and the Supreme Court Judgment. This should include leadership and management workforce capacity, recruitment and retention, skills development, integrated working and workforce regulation across the whole DoLS pathway including Managing Authorities.**

7. **An accredited BIA training programme which provides the practice standards and capabilities to fulfil the role is required. BIA capacity will need to be increased to ensure that Wales sustains access to the appropriate quantity and range of professionals to carry out this function.**

The number of referrals to Independent Mental Capacity Advocates[7] (IMCA) was very low overall across Wales. The role of the IMCA in supporting and representing the Relevant Person and their representative through the complex decision making process is vital, but was not actively promoted by some Supervisory Bodies.

Recommendations:

8. **Supervisory Bodies should develop information for the public, their staff and Managing Authorities that promote the role of the IMCA and encourage a better understanding of their potential contribution to supporting vulnerable people in often very challenging circumstances.**

The governance arrangements within those councils that have both Supervisory Body and Managing Authority functions are not always clearly defined and separated as required in the Code of Practice. Supervisory Body signatories were not always at the level you would expect given the significance of the legislation and impact on the Relevant Person.

Supervisory Bodies were asked whether DoLS activity was reported within their local performance monitoring arrangements as part of the survey component of the national review. Eight organisations stated that this information was not reported and, of those that did, the responses showed that monitoring was not carried out at a consistent level. However, increasingly, this activity is being reported into the Adult Safeguarding Board arrangements and to Scrutiny Committees within councils and Executive Boards of the LHBs. This is an

[7] See Glossary

important shift which illustrates a change in culture across health and social care towards protecting the rights of vulnerable adults and preventing unnecessary restrictions and deprivations.

Recommendations:

9. Governance arrangements must be clearly defined by each Supervisory Body and include, where applicable, how their functions are separated and at what level of management the DoLS Supervisory Body signatories sit.

10 Consistent reporting arrangements for DoLS should be established as part of the performance monitoring arrangements within the Supervisory Bodies and by Adult Safeguarding Boards.

Introduction

The national review took place in April and May of 2014, and involved an electronic survey of the LHBs and local authorities in Wales and fieldwork in all the LHBs and one local authority on each LHB footprint between April and May 2014. This involved looking in detail at a selection of DoLS applications, interviewing the Relevant Person and their Representative[8] (RPR), families, managers and staff in health and social care and focus groups with stakeholder organisations. The review case tracked 84 applications which was 13% of the total number of applications made in 2013/14.

The fieldwork took place shortly after the Supreme Court handed down a judgment in the case of P and Cheshire West which has led to an increase in DoLS applications. The judgment clarified the definition for DoLS and introduced an "acid test" which states that if a person is under constant supervision and control and is not free to leave, then they are deprived of their liberty. This report provides an overview of the survey results, fieldwork and use of DoLS across Wales during this period under the five domains used in the inspection framework.

1. Quality of applications & assessment

Identification and application

The Supreme Court Judgment has clarified the factors that should be considered when determining when DoLS is necessary which has become known as the acid test. At the time of the review, the threshold for an application was not always clear or understood by the Managing Authorities or other third parties. Differing interpretations of the guidance had contributed to inconsistencies in applications and the number of applications in Wales remained lower than expected, given the increasing number of people both in a care home and in hospital who have complex needs which includes a cognitive impairment. This indicates that previously a number of people who should have been supported by having DoLS in place were not.

In the majority of care homes visited as part of the review, knowledge of MCA and DoLS, and confidence in its use, was limited. Managers and staff stated that they were heavily reliant on their local authority Supervisory Body to identify restrictions and potential deprivations, often at the point of admission, and support them through the process. Their lack of awareness of their responsibilities to identify and use urgent authorisations, where necessary, was very concerning. There were a small number of exceptions, which were often those settings which specialise in supporting people with more complex challenging behaviour or who had previous experience of making DoLS applications. Some care settings make several applications each year and others none at all, even though the needs of their residents were very similar.

The question of who should be carrying out capacity assessments was raised with inspectors on a number of occasions and we saw good examples of care homes that were checking a person's capacity on admission and at subsequent reviews. Some councils were very successful

[8] See Glossary

at getting the MCA and DoLS message out to their care home constituency and in supporting them through the process, whilst others did not take a partnership approach and expected the care homes to take responsibility.

Pen y Bont Court Care Home

This care setting had developed a checklist tool to be used on the day of admission or when their circumstances change, for people who may not have capacity. This tool helped them to identify potential deprivations of liberty and take suitable actions such as applying for an urgent and/or standard authorisation, contacting the adult safeguarding team or social worker.

There was also a lack of understanding and awareness about DoLS amongst staff in some hospital settings, although this was beginning to change. The Managing Authorities within hospitals considered the DoLS application process to be overly complex and lengthy. The quality of the applications was consequentially very varied and was most often prompted as part of hospital discharge planning.

There was also a perception articulated by some health staff that DoLS had negative connotations and that an application would reflect badly on their organisation. In addition, there tended to be a focus on patients who demanded and/or attempted to leave and other considerations, such as access to family members, were not taken into account. It appears therefore that the application of DoLS has become a matter of freedom to leave, rather than the freedom to fulfil other aspects of their lives. It was also noted that the NHS has under its care, in a range of settings, a number of people who were previously in long-term hospital beds but whose care arrangements were often very restrictive and DoLS applications had not been considered.

There was no standard or consistent approach to the DoLS application process across Wales. However, in areas where higher numbers of applications were made, the process tended to be clearer and well defined. Some Supervisory Bodies had a system in place for quality checking applications but Inspectors saw a number of errors and omissions in the documentation which could render them invalid and/or subject to legal challenge.

Responsiveness & quality of assessment

The DoLS application consists of six assessments which have to be completed by two separate professionals with appropriate qualifications within prescribed timescales. The majority of the assessments seen were detailed and thorough, with all elements completed as required by the Code of Practice. There were a number of examples of highly complex cases where the Mental Heath Act 1983 had been considered alongside MCA and DoLS. The assessments on the whole were also completed within the timescales required which can be challenging as it is estimated by BIAs that inspectors interviewed, that each assessment can take between 10 and 15 hours.

However, in one area with a high volume of DoLS, there were problems in completing the assessments within the timescales and Managing Authorities had had to extend urgent authorisations. This was exacerbated by the use of very short authorisations which is considered to be good practice as the Code of Practice says authorisation should be for the "shortest period possible". However, we saw examples of situations where the short duration of the authorisation had meant that the Relevant Person's situation had not changed before another authorisation was due and the DoLS system was under considerable pressure due to the number of reviews generated. The focus in these situations seemed to be more on licensing the deprivations, rather than seeking a less restrictive alternative. The increase in the volume of DoLS applications following the Supreme Court Judgment could increase this pressure to authorise deprivations without seeking alternatives.

The Code of Practice was accessible to staff involved in DoLS and was used as a guide for practitioners. Managers and staff considered that the DoLS Code of Practice[9] should be updated to reflect new case law and also stated that further guidance on how and when to make an application would be welcomed. It was suggested that there should be a Wales only Code of Practice as the current version does not necessarily reflect the position in Wales which has significant differences to the arrangements in England. In particular, the NHS organisations in England no longer have supervisory responsibilities. It was also suggested by carers and other stakeholders interviewed during the review that there should be "easy read" versions of the Code of Practice available and that it should be circulated more widely, in particular to the carers' organisations.

Court of Protection applications

The review did not focus on Court of Protection applications and none of the cases tracked during the review involved such an application, either to review their DoLS or for someone in a setting other than a care home.

2. Quality of outcomes

Quality of support & approaches used within safeguards

Where Safeguards are in place, they can contribute to supporting people in very challenging circumstances and are particularly effective where there are bespoke conditions aimed at working towards reducing/removing the deprivation. BIAs can recommend conditions to a DoLS authorisation where necessary which could include, for example, additional staff support or a change in the Relevant Person's care arrangements. However, in practice, conditions were not extensively used in the cases reviewed and, where they were, they had not always been understood by the Managing Authority as requiring their oversight and application to the Relevant Person's care and support arrangements. Inspectors did see a number of very good examples where conditions had been used to great effect to protect an individual's human rights and improve their outcomes.

BIAs in social services confirmed that it was possible to commission less restrictive care arrangements where needed, for example an alternative placement or additional staffing but Managing Authorities expressed more reservations and said that conditions had to be "realistic".

[9] See Glossary

Cwm Taf University Health Board

During the many months the patient was in the hospital, records show that their mental capacity was regularly reviewed with regard to their long-term care and support arrangements. A number of standard authorisations were granted during this time and they were eventually transferred to a care home and a DoLS put in place there. They were subsequently supported to choose to live in their own home in the community.

The outcomes for patients in hospitals who had been subject to DoLS had generally been positive, with a number being supported to return home. In some cases tracked, there had been a multi-disciplinary approach and detailed planning to transfer the Relevant Person to a care home with the new DoLS authorisation as necessary. In cases reviewed where the patient had been under the care of mental health services, we were told by the professionals involved that there was a tendency to use the Mental Health Act 1983 in preference to the MCA and DoLS.

Monitoring & reviews

Managing Authorities are required to monitor the outcomes for the Relevant Person, including making sure that any conditions are reflected in the care and support arrangements, and that qualifying requirements continue to be met. The care homes visited were not always aware of their responsibilities to monitor and request reviews and relied heavily on the Supervisory Bodies to prompt them.

3. Engaging service users, patients & carers

Voice of individuals, carers & representatives

Inspectors spoke to people involved in DoLS, including the Relevant Person (where appropriate), and their carers and representatives about their experiences. All the carers spoke very highly of their experience, despite being initially put off by the terminology and their concern about the premise of depriving their relative or friend of their liberty. Their experience of BIAs was very positive and they felt supported and reassured that their friend or relative was being protected and kept safe. One family member asked why the authorisations lasted for such a short time when it was clear that his mother's situation was not going to change and felt this created a lot of uncertainty for the family.

In practice, the appointment of a RPR was not always approached in a systematic way and, in some areas, very few had been appointed. It was evident that some had made greater efforts to identify RPRs than others. It was also highlighted to inspectors that there can sometimes be a conflict of interest between the RPR and the Relevant Person and, therefore, it is important that the appointment of an IMCA is considered, in these circumstances. We spoke to a number of people who had acted as the RPR, and they stated that they had been kept informed and supported to understand their role and its importance.

Access to advice, information & professional support

The number of referrals to IMCAs is very low overall in Wales, with a few exceptions. There was a perception amongst the organisations providing this service that their role is not promoted or understood by the Supervisory Bodies. However, arrangements for access to the IMCA services are in place across Wales, often on a shared basis with neighbouring authorities and LHBs. The majority of the referrals to IMCAs are prompted by the BIAs and working relationships are generally very positive. Where IMCAs had been involved, the Managing Authorities spoke highly of their knowledge and skills.

Inspectors met with a range of stakeholder organisations, including those from the third sector, and asked about their experiences of DoLS for the people they represented. Their knowledge was quite limited and dependent on the nature of their work, and if they had had any direct involvement. This seemed to confirm that DoLS has not, until recently, been a high profile issue amongst the wider community and in one area the meeting with stakeholders did not take place as the council and LHB did not consider there to be a suitably representative group.

The people we spoke to did generally feel that they had access to the information they needed and in a format that was accessible to them, including in the Welsh language both in the LHB and the council. The information about DoLS was also widely available in hospitals but less so within care homes. Information about complaints and concerns relating to DoLS was not routinely captured by any of the organisations involved in the review.

Equality & diversity

There was evidence that cultural needs had been identified and were reflected in the DoLS assessment, and any conditions put in place through the care and support arrangements. This included providing the information and documentation in Welsh, plus other languages and formats such as Easy Read.

4. Quality of workforce

Leadership & Professional Expertise

The DoLS co-ordinators were found to be the linchpin of the system, and it was often their personal commitment and skill that had the biggest impact on the quality and quantity of applications. This was true both in LHBs and local authorities. The DoLS co-ordination function was often vested in an individual as one of their wider range of responsibilities. They acted as the hub together with their business administration support, both outward facing to Managing Authorities, and internally for the BIAs and Managing Authority functions of their own organisation. Accessibility, approachability and consistency of advice were essential attributes, and we found a number of DoLS co-ordinators who were highly thought of by their peers. In the light of the Supreme Court Judgment, all organisations are reviewing the capacity and skills required to fully deliver on their DoLS responsibilities.

Workforce planning – recruitment, capacity & skills

The recruitment of BIAs had been approached in different ways in the organisations we visited. Usually it was on a voluntary basis, motivated by personal commitment to the principles of the MCA and their own continuing professional development. Some areas had shared their BIA resource across health and social care which both facilitated the independence of the BIA assessment from the team/service which had responsibility for the Relevant Person, and also increased the skill and capacity resource pool of BIAs. The Code of Practice states that efforts should be made to ensure the BIA undertaking an assessment has the professional experience and skills relevant to the Relevant Person's circumstances and condition, eg learning disability. Where BIAs were from one aspect of the service, such as mental health, or one profession, such as social work, then this meant that nursing, occupational therapy and psychology skills and experiences were not available in the BIA pool. This is increasingly the situation in England.

The BIA role was generally perceived as an "add on" by the managers and professionals we spoke to and has no particular status, unlike the Approved Mental Health Practitioner role for example. BIAs stated that they often had to negotiate with their manager to be released to undertake the assessments.

There was evidence that the BIAs have a positive impact on the knowledge base of their colleagues as they act as an internal resource/champion within their teams for DoLS. Historically, a large number of BIAs were trained but were not used due to the low level of applications, especially in some areas. Consequently, there had been a high "drop out" and some reluctance on the part of individual BIAs to do assessments if they lacked the confidence to undertake what is a very significant function and experience of particular settings and services.

At the time of the inspection some health boards had very limited numbers of BIAs at their disposal considering the size of the health boards and the complexity of the needs of some of their patients. Similarly, there were issues of access to Section 12 doctors in some areas. The latter are funded on a fee paid, case by case basis and are approved and trained by Betsi Cadwaladr University Health Board on behalf of all the LHBs in Wales.

Hywel Dda University Health Board

The LHB had nominated staff who act as DoLS links in the hospital settings visited who were able to for provide advice and support to their colleagues on the application of the MCA and the DoLS safeguards. On the site visits it was evident that staff on the wards knew who their link person was and how to contact them for advice on potential DoLS situations.

Training of staff & support for good practice

Training in care homes was provided through the Social Care Workforce Development Programme in some areas. In practice, accessing training was problematic because the courses are oversubscribed and the difficulty in releasing staff to attend. Some individual care organisations also provided in-house training but this was often combined with adult safeguarding training which may partly explain why they do not always understand their specific responsibilities under DoLS. The DoLS co-ordinators also delivered a lot of informal training and awareness raising through attendance at team meetings within managing authorities, including hospitals and social services.

The care home managers we met during the inspection felt that they needed training which focused on developing their decision making skills in applying the MCA to their particular setting and their role in assessing individuals and also more guidance on how to complete the paperwork.

The NHS Core Skills Training Framework does not currently include MCA and DoLS training which staff felt had contributed to it having a lower profile. The survey undertaken of all the councils and LHBs showed that the majority of DoLS training was delivered through a half to one days training with 42% offering an annual refresher and the remainder requiring an update either every two years (23%) or every three years (19%). Training in these areas was only mandatory in 69% of the organisations surveyed, despite the increasing prevalence of patients with dementia and other conditions which can impair their mental capacity. In some areas, staff within the council's adult social care teams had very limited knowledge of DoLS and did not recognise their responsibilities or their contribution to protecting individuals' human rights.

A number of partnerships had good practice exchange forums for DoLS which met periodically to discuss and share learning from complex cases and consider emergent case law. This was valued and well attended but in one location the forum had not met for some time. Similarly, the all Wales DoLS co-ordinators group had not been convened in many months. These forums will be important in the future to sustain the focus on the MCA and DoLS, and the participation of Managing Authorities at this or a parallel forum should be considered.

The training of BIAs is approached in different ways across the Supervisory Bodies in Wales. There has been a longstanding issue concerning the accreditation of BIA courses which was previously undertaken by the General Social Care Council (GSCC) which closed in 2012. This is now overseen by the Department of Health in England through the college of Social Work, however, no new courses have been approved since the GSCC's closure in 2012. This means that some courses being accessed by Supervisory Bodies in Wales are not accredited and others send their BIAs to England to access the courses that are still accredited. This will need to be addressed promptly in order to increase BIA capacity across Wales and ensure the consistency of BIA expertise and range of skills, including ensuring that an appropriate range of professionals have access to BIA training in Wales. The BIAs we spoke to did not always receive one-to-one supervision, either professionally or clinically, for their responsibilities as a BIA.

5. Leadership & governance

Governance & management arrangements for DoLS

The Code of Practice requires organisations with both Supervisory Body and Managing Authority responsibilities to have clear governance arrangements in place to ensure there is a clear separation of roles. In practice this was more obvious in the LHBs, all of whom have both functions and so had detailed and explicit governance structures in place. There was no appetite in the LHBs to change their role to just that of Managing Authority as it was recognised by the health managers interviewed that the MCA and DoLS had to feature in their day-to-day approach to managing patient care.

Of the seven councils reviewed as part of the fieldwork, two no longer had in-house care home provision and were therefore not Managing Authorities. In those that still have both functions; efforts had been made to describe the separation of functions when the arrangements had been put in place in 2009. However, since then the merging of management roles and services has meant that these governance arrangements are no longer clearly defined and separated, and should be refreshed and updated, especially in the light of the Supreme Court judgment.

In the majority of organisations reviewed, the DoLS co-ordination/supervisory functions were hosted within safeguarding teams but, in others, it was located with mental health and learning disability services. Inspectors identified that it is not where the service is located that impacts upon the quality of the service delivered, rather it is the skills and commitment of the individual designated DoLS lead. As DoLS activity increases exponentially following the Supreme Court judgment, local authorities will need to consider what management arrangements will be required. The lead officer/manager for DoLS usually rests at service manager in local authorities and at Deputy Director or Director level in the LHBs.

Partnership arrangements are in place

There were some effective partnership arrangements in place for DoLS which made the best use of resources. As with other partnerships across health and social care, the scale of some LHBs and conflicting priorities makes this difficult to achieve in some areas. The majority had achieved a level of partnership working which ranged from joint management, a consortium supported by a Memorandum of Agreement and hosted by one organisation, to working in collaboration and holding joint practice meetings and sharing training opportunities. The potential benefits of a partnership approach were highlighted earlier in this report and it is likely that further work will be required in this area as demand increases and budgets are reduced. Where partnership arrangements are in place, it is critical that the Executive Boards involved ensure there are clear governance arrangements; including a commitment to sustaining the service and ensuring it has the necessary resources.

Quality assurance & performance monitoring

The Supervisory Bodies were asked to describe their reporting arrangements for DoLS as part of the survey. The information provided indicated an increasing trend towards reporting into the Adult Safeguarding Board and to Scrutiny Committees within councils and Executive Boards of the LHBs. A number of councils also highlighted their intention to include DoLS activity in the Director of Social Services' annual report which is presented to Scrutiny. Some already did so but, in others, it was not clear whether DoLS information was captured and how it was monitored by the executive and elected members.

Carmarthenshire County Council

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

Similarly, quality assurance mechanisms for DoLS applications were not evident and inspectors found a number of errors in individual applications which had not been picked up at the time by the signatory responsible for authorising the deprivation. Inspectors also had some concerns that the Supervisory Body signatory was not always at the level you would expect given the significance of the legislation and impact on the Relevant Person. The level and role of designated signatories should be set out as part of the governance arrangements for DoLS in each Supervisory Body.

Commissioning & DoLS

DoLS did not feature in the contract and service specification or in the contract monitoring arrangements between care homes and local authorities seen during the review. A number of commissioning managers interviewed were now recognising the importance of capturing this information together with complaints, compliments and safeguarding information to build up a picture of their provider constituency. In particular, where they have commissioned services where you would expect there to be a level DoLS activity because of the complex nature of the service, it is concerning that this was not previously monitored by the local authorities or health boards.

Appendices

A. Glossary

B. References

Acknowledgements

CSSIW and HIW would like to thank the individuals, carers and all the staff and managers of the councils and LHBs listed below who took part in the fieldwork for all their help and co-operation with this inspection.

Local Authorities:

Bridgend County Borough Council

Cardiff City Council

Carmarthenshire County Council

Gwynedd County Council

Monmouthshire County Council

Powys County Council

Rhondda Cynon Taf County Borough Council

Local Health Boards:

Abertawe Bro Morgannwg University Health Board

Aneurin Bevan University Health Board

Betsi Cadwaladr University Health Board

Cardiff & Vale University Health Board

Cwm Taf University Health Board

Hywel Dda University Health Board

Powys Teaching Health Board

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Chris Humphrey Lead Inspector, Jill Lewis, Richard Tebboth, Phil Mitchell, Kevin Barker, Ann Rowling, Liz Woods, Marc Roberts.

Healthcare Inspectorate Wales

Evan Humphries Lead Inspector, Einir Price, Dinene Rixon, Rhian Williams-Flew, Margot Dos Anjos.

Appendix A

GLOSSARY: Key terms used in the DoLS Review Reports

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the Deprivation of Liberty Safeguards	All six assessments must be positive for an authorisation to be granted.
Age	An assessment of whether the Relevant Person has reached age 18.
Best interests assessment	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests Assessor.
Eligibility assessment	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
Mental capacity assessment	An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.
Mental health assessment	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.
No refusals assessment	An assessment of whether there is any other existing authority for decision making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.

Best Interest Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
Care and Social Services Inspectorate Wales (CSSIW)	Care and Social Services Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
Conditions	Requirements that a Supervisory Body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor.
Consent	Agreeing to a course of action – specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.
Court of Protection	The specialist court for all issues relating to people who lack mental capacity to make specific decisions. It is the ultimate decision maker with the same rights, privileges, powers and authority as the High Court. It can establish case law which gives examples of how the law should be put into practice.

Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards (DoLS)	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
Local Health Board (LHB)	Local Health Boards fulfil the Supervisory Body function for health care services and work alongside partner local authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being. They separately manage NHS hospitals and in-patient beds, when they are managing authorities.
Independent Hospital	As defined by the Care Standards Act 2000 – a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.

Local Authority/Council	The local council responsible for commissioning social care services in any particular area of the country. Senior managers in social services fulfil the Supervisory Body function for social care services. Care homes run by the council will have designated managing authorities.
Managing Authority	The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.
Maximum authorisation period	The maximum period for which a Supervisory Body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the Best Interests Assessor, and it may end sooner with the agreement of the Supervisory Body.
Mental Capacity Act 2005 (MCA 2005)	The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. The five key principles in the Act are: 1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise. 2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions. 3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision. 4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests. 5. Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Mental Capacity Act Code of Practice	The Code of Practice supports the MCA and provides guidance to all those who care for and/or make decisions on behalf of adults who lack capacity. The code includes case studies and clearly explains in more detail the key features of the MCA
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for mental health treatment, supervised community treatment and guardianship.
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.
Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.

Section 12 Doctors	Doctors approved under Section 12(2) of the Mental Heath Act 1983
Standard authorisation	An authorisation given by a Supervisory Body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.
Supervisory Body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
Supreme Court	The Supreme Court is the final court of appeal in the UK for civil cases, and for criminal cases in England, Wales and Northern Ireland. It hears cases of the greatest public or constitutional importance affecting the whole population.
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a Supervisory Body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

Appendix B

GLOSSARY: Key references for mental capacity act & Deprivation of Liberty Safeguards

Mental Capacity Act The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves

http://www.legislation.gov.uk/ukpga/2005/9/contents

Mental Capacity Act Code of Practice

http://wales.gov.uk/topics/health/publications/health/guidance/mcaconsent/?lang=en

The Supreme Court judgment P (by his litigation friend the Official Solicitor) (FC) (Appellant) v Cheshire West and Chester Council and another (Respondents)

http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care

http://cssiw.org.uk/docs/cssiw/report/140224dolsreporten.pdf