Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Wiltshire and Deprivation of Liberty Safeguards (DoLS)

Executive Summary

This report has been prepared for the Health and Wellbeing Board to ensure that the board are kept up to date with the difficulties experience by the DoLS Service in Wiltshire following an unprecedented increase in referrals for authorisations following the recent Supreme Court Ruling. It is hoped that the report will demonstrate the high level partnership commitment to tackling the issues raised.

Proposal(s)

It is recommended that the Board notes the update.

Reason for Proposal

To keep the Board updated on the issues for the service.

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Wiltshire Council

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Subject: Wiltshire and Deprivation of Liberty Safeguards (DoLS)

Purpose of Report

1. To ensure that the board kept up to date with the difficulties experience by the DoLS Service in Wiltshire Council and the subsequent effect on health care provision within Wiltshire and surrounding areas, following an unprecedented increase in referrals for authorisations following the recent Supreme Court Ruling. It is hoped that the report will facilitate high level partnership commitment to tackling the issues raised.

Background

2. The Deprivation of Liberty Safeguards (DoLS) were developed as a result of the Bournewood judgement in 2004. This situation related to a young man with profound learning disabilities and an autistic spectrum disorder. He was informally kept in hospital (i.e. not detained under the Mental Health Act) against the wishes of his family. The situation as considered through the Court of Appeal, House of Lords, and European Court of Human Rights, where it was finally determined that he had been unlawfully detained.

3. Part of the Mental Capacity Act 2005, but not implemented until 2009, Deprivation of Liberty Safeguards are intended to ensure that people who lack capacity to consent to specific arrangements are not deprived of their liberty or restricted any more than is necessary, and that there are legal routes to challenge situations where it is felt that the level of deprivation is inappropriate. The specific arrangements have, until recently, related to people being accommodated in a Registered Care Home or Nursing Home, or staying in a hospital, for the purposes of receiving care or treatment. This excludes people who are detained under the Mental Health Act, as this legislation affords them the appropriate protections.

4. From 2009, Local Authorities were the Supervisory Bodies (i.e. responsible for authorising Deprivations of Liberty) for people with local Ordinary Residence, in a funded placement in another authority, in both Registered Nursing and Residential Care Homes, and in April 2013 assumed this responsibility in relation to Hospitals, the latter having previously been the responsibility of PCTs.

5. The process for assessing whether a person is :- being deprived of their liberty; and whether or not this is in their best interest; and whether this is the least restrictive option available is very prescribed and many believe the current process and related administrative burden on Councils to be overly bureaucratic. It involves specifically trained staff (Best Interests Assessors or

BIAs and S12 Doctors), and specialist advocacy (Independent Mental Capacity Advocates).

What is a Deprivation of Liberty?

6. If it is thought that a resident or patient in a Residential Care Home, Nursing Home or on a hospital ward requires a level of restriction of freedoms and choices that amounts to “deprivation of liberty” then an application must be sent to the Supervisory Body who are the local Council for an authorisation for this purpose. The definition of a mere restriction of liberty that would not require an authorisation as distinct from a deprivation of liberty that does require an authorisation has never been well defined, and has recently been subject to legal challenge.

7. Broadly, what was happening prior to May of this year was that whether or not a person was being deprived of their liberty was a judgement based on:

   i. Whether the level of restriction on a person’s freedoms were of such a level that they amounted to deprivation of liberty, and if so;

   ii. How reasonable/minimised the restrictions were.

8. Requests for DoLS authorisations were often triggered by extent to which a person appeared to disagree with, be unhappy with, or challenge through their behaviour, the restrictions placed upon them in order for them to receive the required care and support, or treatment.

Based on this definition of a deprivation of liberty Wiltshire Council has historically received the following number of requests for authorisation on a yearly basis	
2013/14 Applications made: 164	Authorisations given: 70
2012/13 Applications made: 154	Authorisations given: 60
2011/12 Applications made: 153	Authorisations given: 70

What Has Changed?

9. In May 2014 the Supreme Court rulings (P v Cheshire West and Chester Council and P&Q v Surrey County Council) has now judged that exactly the same test of deprivation must be applied to all people regardless of their disability who lack capacity, and makes reference to the level of intrusion that result from the care and support arrangements, irrespective of whether a person appears to object to them.

10. The acid test for determining that there is a deprivation of liberty according to Lady Hale in Cheshire West, involved establishing:

   i. That the person is **subject to continuous supervision** and control;

   ii. It was made clear that relevant factor for this could include controlling who the person could have contact with and the activities they could participate

in. However no further guidance was given on what amounted to 'continuous supervision'. One interpretation of this ruling is that all patients or residents in a care home or on a hospital ward are being continuously supervised so it is difficult to see who would fall outside this category;

iii. That the person is **not free to leave.** The area and duration of the confinement is also relevant.

11. Relevant factors for 2, include not being able to leave the placement without supervision and not being free to leave in order to reside somewhere else.

12. Lady Hale maintained in her judgement that one ought to err on the side of caution when determining what constitutes a deprivation of liberty clarifying her thinking in the statement below:

    "If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage."

13. In addition, the judgement has broadened its scope in terms of where the deprivation of an individual's liberty can occur, to include supported living, shared lives, post 18 residential college provisions, hospices and even in the individual's own home. The Supervisory Body function cannot however authorise a deprivation in these settings, applications need to be to the Court of Protection. Those living at home who may be receiving state arranged care support via a LA and whose liberty may be deprived currently will have to be subject to a S 16 MCA welfare application to the Court of Protection.

14. Discussions continue to take place on a national level as to the full implications of the Supreme Court Judgement. A report by the House of Lords has suggested that the DoLS are 'not fit for purpose'. However, in order for the Judgement to be challenged, it must be heard in the European Court. Were this to occur, it is highly unlikely that any revisions would be implemented within the next 24-36 months. As such, there is no option but to adhere to this directive.

Implications for all Councils

15. The implication is that every person who lacks capacity to agree to being accommodated in a residential care home and/or to their care plan will now be considered to be deprived of their liberty, and therefore the processes for authorising Deprivation must be followed.

16. NHS commissioned Healthcare providers should now be applying to the Council for authorisation for deprivation of liberty for people who cannot consent to being in hospital or their treatment, because they are unconscious, unless they have given prior consent such as for elective surgery.

17. Deprivation of Liberty authorisations can only be for an absolute maximum of a year, after which the full process must be undertaken again. Should a deprivation be authorised for a shorter period, that authorisation cannot be ended or extended without the full process being undertaken. Ongoing authorisations will need to be repeated for some people year on year if they remain deprived of their liberty.

18. Those living at home who may be receiving state arranged care support via a LA and whose liberty may be deprived currently will have to be subject to a S 16 MCA welfare application to the Court of Protection. Every referral to the Court of Protection involves significant preparation, and has a minimum cost of £400 (at 04/2014). In addition, the Court may decide to appoint an Official Solicitor and require the appointment of a range of independent practitioners (for example Social Worker or Psychiatrist) to carry out independent assessments to assist the Court to make a decision on what arrangements are in the person’s best interests. The costs of such appointments are borne by the parties involved, and in the circumstances under consideration here, by the party seeking authorisation of the deprivation of liberty. This will either be the NHS or the Council, although depending on the outcome of the financial assessment, the person who is the subject of the Court referral may be required to pay their own costs or refund the council if they are not eligible for Legal Aid.

19. There is significant concern nationally about the implications of this judgement, the burden placed upon Councils and the NHS is significant, and the implications for families cannot be underestimated. The increase in Council involvement with people who fund their own support as a result of the Care Act will increase this burden even further, as even advising families on how to support people safely may result in involvement in a referral to the Court of Protection. Further legal clarification on this point will be needed next year.

Wiltshire Councils Response to the increase in demand for authorisations.

20. In the six months since the ruling was made in March 2014, Wiltshire – in common with other local authorities – has been grappling with the additional demands this has placed on our resources. 500 assessments are yet to be allocated to Best Interests Assessors, meaning that statutory time scales are not being adhered to. Currently the Wiltshire DoLS service receives 30 requests for authorisations on a weekly basis.

21. Unlike a number of other County Councils who have relied on independent best interest assessors to complete the back log of assessments Wiltshire has taken a view that a sustainable solution must be found that will not only address the current back log but also puts us in a secure position to cope with the increase in demand throughout the coming years.

Short-Term Support and Mitigation of Corporate Risk

22. The following steps are already being taken to mitigate Wiltshire Councils’ corporate risk and to support current service delivery in the short term:

a) 12 month secondment of a senior BIA to the DoLS team (June 2014 to June 2015)

b) Some funds have been made available for additional BIAs to be recruited via Social Work agencies but recruitment is almost impossible because of the national demand.

c) 30 hours of additional administration support, to assist with the increase in admin.

d) The formation of a Task & Finish Group which meets 4 weekly to review service pressures and corporate risks and take action to make improvements.

e) Commissioned bespoke Wiltshire Council training programme from Bournemouth University, leading to the training of 20 new BIAs who should be fit to practice by December 2014 (longer term benefit)

f) Maintaining links with neighbouring authorities in order to develop joint strategies & approaches

g) Commissioning Independent BIAs when available to undertake assessments in the short term.

h) Keep abreast of National Directives (ADASS, DoH, COP)

i) Work in partnership with legal services, who are taking forward work in relation to DoLS applications for people who are not in care home or hospital settings

j) As well as an increase in assessments there has also been a knock on effect for the admin side of the team. 1 full time additional administrator to support the DoLS Service full time for a six month period – currently at recruitment phase. Streamlining administration tasks has begun so that these require less staff time.

k) As customers and their families are often supported by independent advocates or IMCA's this has increased the number of referrals to SWAN advocacy. Ongoing this will have a cost implication for the council and must be adequately resourced to ensure that customers and their families are supported throughout the DoLS process if required.

l) The following criteria has been devised as a way of prioritising requests being made:

   i. Is the person in an acute or psychiatric hospital or hospice?
   ii. Is the person experiencing high levels of distress as a result of the arrangements in place?
   iii. Would the person have met the requirements for a DoLS Authorisation prior to the Supreme Court Judgement in March 2014?
   iv. Is anyone objecting to the arrangements in place on the person's behalf?
   v. Is the person subject to safeguarding procedures?

23. The following mitigating actions are being taken by NHS Wiltshire CCG for commissioned services:
- A regular update is provided at monthly Clinical Quality Review Meetings by providers to the commissioners. Wiltshire CCG has to take into account the different approach of Bath and NE Somerset and Swindon Borough Councils, particularly in relation to cases referred to the coroner following the death of a patient whose assessment has not been completed. The Wiltshire coroner's view is different to that of the other councils and has caused concern for providers.

- NHS Wiltshire CCG is working with the University of West of England to provide bespoke training for all commissioner and provider Safeguarding leads within Wiltshire, the following is currently under development and the programme will begin in January 2015:

    1) Launch event
    Led by the Head of Adult Safeguarding, NHS Wiltshire CCG and UWE, launch followed by cafe style workshops with some trigger questions that will help further inform action learning sets. Four UWE academics are involved in the planning, desk top research of the topics and current best practice in preparation of the whole project and for facilitation at the launch event.

    2) Action learning sets
    Two hour events over 12 weeks with safeguarding leads from end Jan/Feb 2015. Five action learning groups facilitated by academics with participants focused learning relating to designing a policy, action plan or demonstrating application to practice. The number may be defined by the launch workshop and take place off UWE premises to be decided by the action learning group membership.

    3) Master classes of themed rolling programme
    Themes: MH Act and Advocacy, MH act and noncompliance, MH act and DNAR decisions, and MH act and restraints. Face to face approach using case studies. Two hour sessions with approx. 20 per group from end of January. Ambassadors under the mentorship of UWE academic facilitators will roll out these master classes.

    4) Rapid immersion event
    One day event for a mixed audience that would be themed around the MH capacity act. Two UWE academics will lead the day and to do an evaluation report.

    5) Evaluation
    Baseline audit to begin with identifying what is available now and then, following the above interventions, an evaluation to ensure these made a difference to practice.

24. NHS Wiltshire CCG is committed to sharing best practice across Health and Social Care, this programme has been supported by NHS England and has

been identified as an area of Best Practice. The CGG is now sharing with other CCGs to ensure a joined up approach.

Medium to Long-Term Support and Mitigation of Corporate Risk

25. The following steps are already being taken to mitigate corporate risk and support current service delivery in the medium to long term:

    a) Agreement has been reached for all newly training BIAs to be released from duties in the operational teams to complete one best interest's assessment a week. From January 20 BIAs will be available to do this work. The total number of assessments that can be completed as a result of the increase in available BIA's from January 2015 to January 2016 will be **1040.** This will clear the back log of assessments.

    b) As this level of assessment will cover the back log but not the additional assessments that are coming through an ongoing training programme has been implemented and we are identifying further Wiltshire Council employees in a position to undertake 6 month BIA training starting in January 2015. It is anticipated that all level 2 Social Workers with at least 2 years post qualifying experience and all level 3 social workers will receive training as a BIA on a rolling programme and then be available to undertake assessments on a weekly basis. In this way if or when trained members of staff leave the Council we are able to maintain a sustainable number of BIAs for the requests that are coming in.

    c) The DoLS Lead encourages a verbal discussion with service providers prior to the submission of requests, to ensure that basic criteria are met – several providers still fail to recognise that the mental capacity requirement has to be met, in order to pursue an Authorisation under DoLS.

    d) Wiltshire Council & Swindon Borough Council have a Care Skills Partnership Group which has and continues to identify information which will help to inform providers about the changes in legislation and practise, specific to these geographical areas.

    e) The WSAB have agreed to undertake a small scale audit of how DoLS matters are addressed during safeguarding work. The purpose is to identify good practice and also issues that need further development or reinforcement through targeted training. This is likely to take place in December or January in view of the current pressures on the DoLS team.

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