Agenda item 6

Health and Wellbeing Board
24 January 2014

DEPRIVATION OF LIBERTY SAFEGUARDS

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1. Summary

1.1 The Deprivation of Liberty Safeguards were introduced in April 2009 as an amendment to the Mental Capacity Act 2005. The safeguards provide protection for vulnerable people against arbitrary detention. They apply to people 18 and over who lack mental capacity to consent to be accommodated in hospitals or care homes. They apply only where the person has a mental disorder and where care or treatment cannot be provided in a less restrictive way.

1.2 A care home or hospital is required to consider whether its interventions amount to a deprivation of liberty and if so to make a referral to the Local Authority (known for these purposes as the Supervisory Body - SB) for an authorisation to continue to deprive the person of liberty in their best interests.

1.3 Assessments are carried out by two independent professionals; a s12 Approved doctor and a Best Interests Assessor (BIA). Once the required assessments are completed they are produced to the SB who then grant or refuse an authorisation. Senior staff in the Council are appointed as DoLS Authorisers.

1.4 The DoLS team is located in Ptarmigan House with the MCA/DoLS Manager. This service supplements the main Mental Capacity Act provision of the Council which is jointly funded by Shropshire Council and Shropshire CCG to ensure consistency across the health and care economy.

2. Recommendations

2.1 The Health and Wellbeing Board to receive quarterly statistics in relation to DoLS applications and to analyse them relative to the other West Midlands authorities.

2.2 The Health and Wellbeing Board to receive reports from the MCA/DoLS Operational Group which meets quarterly.

2.3 The Health and Wellbeing Board to receive a report following Shropshire's participation in the West Midlands regional peer audit.

REPORT

3. Level of DoLS activity 2012/13 for Hospitals

3.1 There were 17 requests from SATH which related to 13 different people. Additionally two of these people had three requests within the period.

3.2 Additionally last year there were four requests from RJAH (2 people) all granted, one request from Chirk Community Hospital which was granted, one request from Queen Elizabeth Hospital, Birmingham not granted as the patient had absconded and one from St Georges Hospital Stafford (there is a specialist ALD unit there) which was granted. In the case of the absconding patient an Adult Safeguarding referral was made to Birmingham.

SOURCES OF HOSPITAL DOLS REFERRALS 2012/13	NUMBER	GRANTED	NOT GRANTED
SATH	17	8	9
RJAH	4	4	
BISHOPS CASTLE CH	0	0	
BRIDGENORTH CH	0	0	
LUDLOW CH	0	0	
WHITCHURCH CH	0	0	
ST GEORGES	1	1	
QE BIRMINGHAM	1	0	1
CHIRK CH	1	1	

Level of DoLS activity 2012/13 Care Homes

3.3 There were 81 requests of which 51 were granted and 30 not granted.

3.4 Numbers of assessments completed April 2012 to March 2013 compared to previous years

Assessments month by month	2009/10	2010/11	2011/12	2012/13	2013/14
April	4	8	8	4	12
May	7	10	9	6	12
June	2	7	15	3	12
July	2	16	12	14	18
August	3	8	9	9	13
September	5	11	12	10	20
October	6	4	13	12	18
November	6	6	6	8	14
December	10	5	9	11	12
January	4	9	10	11	
February	5	8	12	10	
March	8	15	6	7	
Total	**62**	**107**	**121**	**105**	**131**

Comparison with West Midlands (Appendix One)

3.5 West Midlands data is attached including per head of population. From this table it can be seen that the numbers of referrals from Shropshire are consistently above the West Midlands average. Shropshire is 7th in terms of population size but had for 12/13 the 4th highest referral rate. Birmingham is the largest local authority area yet is the 5th highest in terms of DoLS requests. In terms of per head of population Shropshire is 3rd highest with Birmingham being the lowest.

3.6 In terms of hospital requests Shropshire is about halfway down the list of authorities. Birmingham is highest in this respect. Hospital DoLS make up approximately 30% of all referrals but the lack of referrals from Community Hospitals last year is of concern.

Areas of regional and national engagement

3.7 The MCA/ DoLS Manager has summarised a number of case studies where DoLS has produced a successful outcome for the service user, these have been produced in Community Care magazine and other work in 30 Essex St mental capacity law newsletter. Case examples were also shared with the DH and with SCIE and included in a Good Practice Guide.

3.8 The MCA/DoLS Manager has been Chair of the Regional DoLS Leads Group for the last 2 years. The group has produced some significant work over the last year. Through links developed from this group the MCA/DoLS Manager gave evidence to the House of Lords Select committee on Mental Capacity Act implementation along with the ADASSS representative.

3.9 Extensive work has been carried out across the region spearheaded by Shropshire to review the DoLS Forms. The DH is aware of this work and has had copies. Checklists of best practice were developed for BIA's and for Authorisers.

3.10 The Leads group has recently reviewed the original ADASS DoLS protocol and this has been submitted to the Chair of the ADASS Mental Health Network to take forward. The MCA/DoLS Manager is to attend the ADASS mental Health Network national meetings.

3.11 The safeguarding systems coordinator is part of the national DoLS Development Group which is chaired by the Section Head, Adult Social Care Statistics (HSCIC). The key aim of this group is to operationally manage and develop the DoLS collection from 2013/14 to reflect the requirements of users and policy.

3.12 The West Midlands Regional DoLS Leads group have begun a regional peer audit of best interest's assessments and the matching standard authorisations. This is unique work and not mirrored anywhere else in the Country. A report of the findings along with any action plans will be produced in March 2014.

Training and promotion

3.13 Training sessions are provided by the Staff Development Officer (MCA) and the MCA/DoLS Manager provides additional higher level training across the health and social care workforce.

3.14 Demand is growing for training in MCA and DoLS rather than reducing. Courses are generally over-subscribed and take up is good across the health and social care workforce.

All MCA & DOLS courses by Sector 2012/13

Sector	Attendance
Acute Hospital	173
Housing	1
Independents	515
SSS NHS Foundation Trust	12
Community Health Trust	330
Shropshire Council	255
Voluntary	72
T & W Council	31
Out of County	231
Total	1620

Annual update training is provided for authorisers and regionally (arranged and facilitated by Shropshire) for BIA's and doctors.

Joint Working arrangements

3.15 The joint working arrangements have been confirmed between SC and SCCG from 2013 onwards. The continuation of the Joint Working arrangements mean that SC can continue the post of Training Officer which is 0.5 of a post and thereby meet the training requirements of both organisations.

3.16 This post enables SC to provide training for the Acute hospitals and Shropshire Community Health NHS Trust and South Staffordshire & Shropshire NHS Foundation Trust should they require it. Training is also provided to GP's.

3.17 The joint arrangement does not include T&W CCG or local authority; therefore training is geographically specific whilst SATH is across both sites.

4. Risk Assessment and Opportunities Appraisal

4.1 Following the Health Committee scrutiny of the Mental Health Act and after the findings are released of the House of Lords scrutiny of the Mental Capacity Act there is likely to be increased audit from DH of the work of local authorities and partners in relation to compliance with the law.

4.2 There will be a clear focus on vision, priorities and strategies which have MCA/DoLS embedded in them. There will be a need to demonstrate strong partnership commitment to initiatives to support people who lack capacity.

4.3 Mechanisms need to be in place to provide evidence of the work which is taking place in Shropshire. There need to be clear arrangements to co-ordinate the work and evidence that challenge is provided of the outcomes for people who use services.

5. Financial Implications

5.1 The continued success of MCA implementation in Shropshire is reliant on the joint working arrangements funded by the recurrent MCA grant from DH and NHS England.

6. Background

7. Additional Information

7.1 Attached at Appendix Two is a summary of some recent case studies in relation to DoLS and successful outcomes for residents of Shropshire.

8. Conclusions

8.1 Mechanisms need to be in place to evidence strong partnership working in relation to MCA and DoLS. Partners, senior executives, non-executives, councillors, commissioners, regulators, providers, and organisations representing disabled and older people and patients need to work together to ensure people who lack capacity are safeguarded.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Karen Calder
Local Member

Appendix One

DEPRIVATION OF LIBERTY - WEST MIDLANDS REPORT FOR LA's AND PCT's 1 April 2012 - 31 March 2013				
AREA	Adult Population		Total Number of standard authorisation applications from 1st April 2012	Total Number of standard authorisation applications from 1st April 2012 per 100,000 Adult Population
Birmingham	782,400	LA	48	6.1
Birmingham East and North	782,400	PCT	17	2.2
Heart of Birmingham Teaching	782,400	PCT	14	1.8
South Birmingham	782,400	PCT	19	2.4
Birmingham Total				12.5
Coventry	247,500	LA	97	39.2
Coventry Teaching	247,500	PCT	24	9.7
Coventry Total				48.9
Dudley	241,800	LA	59	24.4
Dudley	241,800	PCT	33	13.6
Dudley Total				38.0
Herefordshire	144,100	LA	60	41.6
Herefordshire	144,100	PCT	10	6.9
Herefordshire Total				48.6
Sandwell	223,300	LA	53	23.7
Sandwell	223,300	PCT	28	12.5
Sandwell Total				36.3
Shropshire	233,500	LA	81	34.7
Shropshire County	233,500	PCT	24	10.3
Shropshire Total				45.0
Solihull	161,200	LA	35	21.7
Solihull Care	161,200	PCT	11	6.8
Solihull Total				28.5
Staffordshire	663,200	LA	172	25.9
North Staffordshire	663,200	PCT	10	1.5
South Staffordshire	663,200	PCT	26	3.9
Staffordshire Total				31.4
Stoke	188,400	LA	66	35.0
Stoke on Trent	188,400	PCT	14	7.4
Stoke Total				42.5
Telford & Wrekin	125,000	LA	43	34.4
Telford & Wrekin	125,000	PCT	10	8.0
Telford & Wrekin Total				42.4
Walsall	196,300	LA	17	8.7
Walsall Teaching	196,300	PCT	18	9.2
Walsall Total				17.8
Warwickshire	424,800	LA	29	6.8
Warwickshire	424,800	PCT	37	8.7

Warwickshire Total				15.5
Wolverhampton *	186,600	LA	55	29.5
Wolverhampton City	186,600	PCT	19	10.2
Wolverhampton Total				39.7
Worcestershire	442,500	LA	90	20.3
Worcestershire	442,500	PCT	41	9.3
Worcestershire Total				29.6
WEST MIDLANDS TOTAL	**4,260,600**		**1260**	**29.6**

	West Midlands
	Above West Midlands Average per 100,000 adult population
	Below West Midlands Average per 100,000 adult population

APPENDIX TWO
A selection of recent DoLS case examples

CASE EXAMPLE: SUPORTED DECISION MAKING

A young woman with a learning disability was admitted to an acute hospital due to extreme weight loss and muscle wasting - she was non-weight bearing. She was transferred to a Community Hospital. During her stay many issues of concern were identified. She was a selective mute and was controlled at all times by two members of her wider family. She had been removed from school and from "the system" at age 12. The family members remained with her at all times. After an assessment of capacity a P.E.G was fitted to feed her. This was opposed by the family and was subsequently cut twice during the hospital stay. A DoLS authorisation was put in place and family visits were restricted to outside of therapeutic interventions. The young woman could not use cutlery and did not appear to be familiar with many foods. Her capacity was in doubt mainly due to her refusal to communicate by any means. The DoLS authorisation on the ward allowed for necessary therapeutic interventions to take place. Following hospital she was moved to a care home and another DoLS authorisation was put in place. Due to the restrictions on family visits and the opportunity for therapeutic input her language returned and she regained capacity, eventually moving into supported employment and living independently with minimal support.

CASE EXAMPLE: ROLE OF BIA IN ENSURING MCA IS FOLLOWED AND PROMOTING LESS RESTRICTIVE OPTIONS WHILST BALANCING RISK.

Mr B is an 89 year old widow who lives alone in a detached bungalow. Notably he was a fighter pilot during the Second World War flying Hurricanes and Spitfires in the Far East.
He was admitted to an Acute Hospital as a planned admission to have a right knee replacement operation. Following surgery he was transferred to a rehabilitation Ward. A head CT scan indicates extensive bilateral chronic ischaemic change, with atrophy and generalised ventricular dilation and increase in CSF spaces. Initially Mr B was agitated post-operatively, trying to get out of bed and mobilise when he was unable to. Subsequently, although this settled down, he continued to demand to leave.
A DoLS Authorisation was issued for three weeks because Mr B was making purposeful efforts to leave. He clearly expressed his wish to return home. He attempted to leave and the exit door was locked. Mr B continued in his determination to return home. He was unable to remember his address. He did not acknowledge that he had care needs and was "not too worried" about returning home. He appeared to lack insight into his care needs.
The doctor said that Mr B would be "unsafe" to return home due to his cognitive impairment. He said he had "failed" the OT assessment and his inability to sequence actions and his lack of insight into his care needs would pose risks. He said that a likely placement would be an EMI residential setting. No home assessment had taken place. His only relative wanted him to return home at least for a trial.
A Best Interest meeting was arranged. No home visits or home assessment had taken place as it was felt Mr B would refuse to return to the ward. The social worker expressed concern at Mr B's lack of insight into his own care needs however no contact has been made with Mr B's neighbours. It was confirmed Mr B was not previously known to social services, his GP had not expressed concerns.
The social worker was reminded by the BIA that less restrictive options must be investigated.
The BIA attended the Best Interests planning meeting and a decision was made that Mr B should return home with a care package, which he subsequently did. He remains well at home.

CASE EXAMPLE : CAPACITY, RISK AND THE ROLE OF PAID PERSONS REPRESENTATIVE (P.P.R)

Mr A is 85 with early stages dementia and short term memory problems. He was admitted to a Residential Care Home following a breakdown of care at home. His wife has physical problems and is wheelchair bound. They have been married for 66 years. On admission he presented as having some self-neglect issues.

His wife had initially refused to have him back home. Mr A was adamant that he wished to return home. This resulted in a DoLS Authorisation.

When the BIA met Mr A he appeared low in mood. He was able to communicate verbally, but appeared withdrawn and distant. His communication was limited. He said that he "wanted to go home" and that he had been ringing his wife to tell her but "could not get through". He accepted that he needed help with personal care and would benefit from a care package on his return home. He expressed his frustration at not being able to return home through his words and facial expression. His medication had recently been changed.

The PPR expressed significant concern about Mr A's "low and flat" presentation. She was strong in her opinion that his needs must be considered of equal value and merit as Mrs A's. She commented that as shared occupants of the home he had as much right to live there as his wife. She expressed the view that if the placement was made permanent she would be very concerned about his mental state.

The Social Worker expressed on-going concern regarding the situation at home mainly due to a previous incident where Mr A went out to the shops and got on a bus and was returned by Police after getting lost.

After a short respite break Mrs A later stated that she wished her husband to return home. She stated "they won't let him home unless there is a (care) package in place". "I do want him to come home with a bit of support".

Mr A's medication was reviewed as both BIA and PPR had found him to be sleepy, withdrawn and uncommunicative. His medication was reduced significantly and within a few days he was assessed to have capacity to make the decision about where he is accommodated for care and as such plans were put in place for a speedy return home.

This case demonstrated the role of the PPR and the BIA as advocate and also highlighted the different attitudes towards incapacitated risk taking and capacitated risk taking. Professionals were much more cautious, highlighting risk rather than promoting autonomy at the time they felt Mr A lacked capacity. Once he was assessed to have capacity their concerns fell away.

CASE EXAMPLE - INTERACTION WITH SERIOUS MEDICAL TREATMENT

A man with a brain tumour was in an acute hospital. A DoLS authorisation was in place on the ward as he was constantly trying to leave - he was wandering about the Ward trying to get home, agitated and aggressive to staff.

He had been referred to a specialist hospital, with a view to surgery. They had concluded that there was no surgical intervention possible and he was to be treated conservatively. The hospital had omitted to make a Serious Medical Treatment referral to an IMCA as the proposed treatment was in fact no treatment. The BIA identified this error and an IMCA was instructed retrospectively.

CASE EXAMPLE: ENVIRONMENTAL CHANGES TO CARE PLAN

A man with dementia was placed in a care home. The home found the man very difficult to manage as he was inclined to want to walk at will and without purpose. This usually included him going into other people's rooms. The care homes response to this was to place him on the first floor in a corridor which they locked at both ends. This of course limited where he could walk and made it inevitable that he would go into other people's rooms.

The other residents on the corridor were all bed bound so locking the corridor was purely to deal with his behaviour. It was described as an EMI wing but it was a corridor with bedrooms there were no social rooms. The man was not sleeping, very bored and isolated. The family mistakenly thought this was a symptom of his dementia and so initially supported the actions.

The BIA made the requirement as a condition of the DoL that the locks were removed and attempts were made to involve the man in social activity. Following this the man was transferred down stairs. He enjoyed sitting in the conservatory, having a wider area to walk in, he began singing along with Welsh choirs and began to play board games. The staff were greatly encouraged by the change in his demeanour and presentation. It had just not occurred to them to take this action before the involvement of the BIA

CASE EXAMPLE : LESS RESTRICTIVE OPTION

Mr J was admitted to a care home following the death of his wife. He had a diagnosis of Dementia. The family were very concerned about his ability to cope alone at home. His daughters who have an LPA for health and welfare decisions live some distance away. Mr J was not expressing a wish to return home but to go out for long walks whenever he wished, as he previously did from home. He was described by his daughters as someone who needed to be outdoors.

A DoLS Authorisation was in place for two months in order to see what further positive effect the substantial family support and frequent visits would have on his experience of residing in the care home. This period would also allow time for family to consider and if possible to implement the use of a volunteer to facilitate walks out and possibly share and encourage his enjoyment of books.

The "relative normality" of his life was emphasised throughout the DoLS assessment process. Mr J had independent access to a secure garden and courtyard, and both staff and family often enabled him to go out for accompanied walks. But until admission it was normal for him to go out as often as he wished on his own – which he did several times daily. For this to be limited , as it was in the care home, represented for him a severe and incomprehensible restriction, giving rise to intense and repeated frustration and agitation. The DOLS assessment identified this as the main issue/problem for Mr J and stimulated discussion around this.

The DOLS process involved the family and acknowledged their highly significant role and reinforced the importance of their contribution to his well-being. It highlighted the importance of emotional/psychological well-being and presented a challenge to traditional residential care arrangements which tend to focus on protection against risks.

Mr J did not "settle" and continued to be frequently frustrated/ agitated because he was not allowed out despite intensive family efforts to visit and accompany him out several times weekly. This led family to question whether residential care was in fact the best arrangement for him.

The BIA helped family to consider and identify a less restrictive alternative, a return home with formal care in place and family support. The subsequent best interests meeting concluded that the benefits to Mr J of being enabled to return home with support outweighed the risks.

Mr J returned home and remains at home.