Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Capacity Act 2005

Deprivation of Liberty Safeguards

Annual Monitoring Report for Health

1 April 2009 to 31 March 2010

Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Tel: 029 2092 8850
Fax: 029 2092 8877

www.hiw.org.uk

ISBN 978 0 7504 6072 9

WAG10-11549
F7891011

Contents

Foreword

I have pleasure in introducing the first annual report relating to the monitoring of the implementation and application of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (the Safeguards), across Wales. The Safeguards came into force on 1 April, 2009.

When an individual lacks mental capacity to consent to care or treatment, it is sometimes in their best interests to deprive them of their liberty so that they are protected from harm. However, it was found necessary to introduce the Safeguards when the European Court of Human Rights (in the *'Bournewood Case'*) ruled that an individual had been unlawfully deprived of their liberty while being cared for in a hospital setting. The Safeguards provide a framework to ensure that individuals are only deprived of their liberty when there is an absolute need to, when it is in the individual's best interests to do so and when other less restrictive arrangements have been considered but found to be inappropriate.

The Safeguards set out procedures for hospitals and care homes to obtain authorisation to deprive someone of their liberty. Without that authorisation the deprivation of liberty will be unlawful.

Our monitoring role in relation to the implementation and application of the Safeguards is fundamental to our commitment to protecting those who are most vulnerable. The information gathered in this first year will be used to inform the further development of our approach to monitoring.

The information in this report will be of interest not only to those responsible for implementing and monitoring the new safeguards, but also to individuals who are at risk of being deprived of their liberty and their families.

Peter Higson

Chief Executive
Healthcare Inspectorate Wales

Executive Summary

The Deprivation of Liberty Safeguards (the Safeguards) were introduced as amendments to the Mental Capacity Act 2005 on 1 April 2009. They are designed to protect vulnerable people against overly restrictive care while they are in hospital or being cared for in a care home.

Healthcare Inspectorate Wales (HIW), on behalf of Welsh Ministers, is responsible for the monitoring of the implementation and application of the Safeguards by healthcare organisations across Wales. In so doing we are required to form a view as to whether the Safeguards are being properly utilised to safeguard the human rights of those who lack capacity to agree to their care and treatment.

This is HIW's first annual monitoring report on the implementation and application of the safeguards by healthcare organisations across Wales, and uses data and information provided by Health Boards (HBs)[1] together with information we have gathered as part of our routine inspection work. A separate report on the application of the Safeguards by care homes has been prepared by the Care and Social Services Inspectorate Wales (CSSIW) see:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=744&pid=36235

Before the Safeguards were introduced an impact assessment[2] was undertaken by the Department of Health which estimated that approximately 500,000 people across England and Wales who lacked capacity and were therefore unable to consent to their care arrangements and treatment were living in institutions (either hospitals or care homes). This group of people was considered to include: individuals with dementia (the largest group); individuals with severe learning disabilities; those with mental health difficulties; and others who lack capacity, for example because of

[1] The organisations responsible for managing the process for authorising requests from Welsh healthcare organisations to deprive someone of their liberty.
[2] Impact Assessment of the Mental Capacity Act 2005 deprivation of liberty safeguards to accompany the Code of Practice and regulations.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982

acquired brain injury. A study undertaken in 2000 by the Department of Health concluded that of the 500,000 individuals around 50,000 (1 in10) would require restrictions to be put in place to safeguard them.

Therefore, as well as providing an overview of the systems and processes that have been put in place by healthcare organisations across Wales, this report includes some comparisons of planning assumptions with actual volumes of activity.

Summary of our Findings

Overall, we have found that a great deal has been achieved during the first year of the Safeguards' operation. We consider they have made real improvements in protecting individuals' human rights and in providing a clear process for managing requests for deprivation of liberty on safety and welfare grounds. However, there are some clear areas that need further development. We have found that:

- The total number of applications made under the Safeguards was much lower than expected (547[3]) across Wales compared with the number predicted for in England and Wales which was around 21,000. Of the 547 applications made only **135** were made by healthcare organisations.
- A much higher percentage than expected of the 135 applications made by healthcare organisations was successful (57% compared with the predicted 25%).
- There was a wide variation in the number of applications made by healthcare organisations across the seven HB regions, ranging from **six** applications in Hywel Dda to **34** in Cardiff and Vale. The variance is not directly related to population size and we expect that a more consistent pattern will emerge over the next 12 months.
- The majority of applications made related to individuals who were older, white and female. This profile is in line with the predictions set out in the impact assessment undertaken by the Department of Health.

[3] Figure relates to applications from health and social care organisations.

Applications made by healthcare organisations accounted for 25% (135) of all applications made across Wales, with care homes accounting for the remaining 75%. The ratio of applications made by social and health care organisations was as predicted.

- 84 (62%) of applications were made following an urgent authorisation. In each case a person was deprived of their liberty for the 7 days allowed for the processing of a standard authorisation and 44% (37) of these applications were rejected. The high number of urgent authorisations made in the first year of the Safeguards could be because healthcare staff were not fully understanding of the boundary between what are protective restrictions and a deprivation of liberty.
- The provisions within the Safeguards which allow family members and others to protect an individual have been used infrequently in the first year. We believe this is due to a lack of information being available to the public.

While the Deprivation of Liberty Safeguards have been implemented in relation to a relatively small number of people, where they have been utilised they have touched on the human rights of that person. These individuals are already vulnerable because of their mental disorder and mental incapacity, and must be appropriately protected. It is important therefore that the Safeguards are used appropriately and effectively.

Although a great deal has been achieved in this first year and some clarity has developed around the benefits the Safeguards can bring to individuals, it is clear that public understanding of the Mental Capacity Act and its Safeguards is under-developed. The Mental Capacity Act highlights the value of planning ahead; so that people make choices when they have capacity that can inform decisions should their capacity become be reduced later on. People can only benefit from the Safeguards if they are aware of them and guidance is made clear.

The variability of practice highlighted in this report must be properly evaluated by healthcare organisations. They need to ensure that all staff understand and properly apply the Safeguards and the Mental Capacity Act more generally. It

must be understood that the Safeguards affect all who work in the health sector, not just those who specialise in providing care and treatment to those with a mental health issue or learning disability.

Over the year ahead we will continue to monitor the application of the Safeguards as a matter of routine and the information gathered in this first year will be used to inform the further development of our approach.

Chapter 1: The Deprivation of Liberty Safeguards and why they were Introduced

1.1 The Deprivation of Liberty Safeguards (the Safeguards) were introduced as an amendment to the Mental Capacity Act 2005 in April 2009. They were introduced to protect people in hospitals or care homes, over the age of 18, who are experiencing mental incapacity[4] and who may have had their freedom restricted for their own protection. They provide a legal framework around the deprivation of liberty which is aimed at preventing breaches of the European Convention on Human Rights (ECHR).

1.2 Two linked Codes of Practice have been developed to provide guidance to anyone working with individuals who may lack capacity. One[5] outlines the way the Mental Capacity Act should be operated and the other supplementary code focuses on the Deprivation of Liberty Safeguards in detail (the Code)[6]. The Mental Health Act Code of Practice for Wales[7] is also relevant as it provides guidance and information for those responsible for ensuring the implementation of the Safeguards on a daily basis. This highlights that:

> *'the deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983.*
> *The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.'*

[4] Mental incapacity is where individuals have medical conditions which affect their ability to make certain decisions about their own wellbeing, safety or health, either in the short or longer term. Common examples of these conditions can include Alzheimer's disease, stroke and brain injuries.
[5] http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=744&id=116382
[6] http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=744&id=116403
[7] http://www.wales.nhs.uk/sites3/page.cfm?orgid=816&pid=33960

1.3 While those providing care or treatment should take every step to prevent deprivation of liberty it is accepted that sometimes it cannot be avoided. In such circumstances the organisation caring for the individual should ensure that he/she is not deprived of his/her liberty for longer than is necessary.

1.4 The Safeguards have put a framework in place that requires hospitals and care homes to comply with an authorisation process which is designed to ensure that any decision to deprive a person of their liberty is properly considered and justified. They, together with the accompanying Code of Practice clearly set out:

- **The process for making an** application for the authorisation of a deprivation of liberty.
- **Details of** how an application for authorisation should be assessed.
- **What requirements** must be fulfilled for an authorisation to be given.
- **The process for reviewing an** authorisation.
- **Details of the** support and representation that must be provided to individuals who are subject to an authorisation.
- **The way in which** people can challenge authorisations.

Who do the Safeguards apply to?

1.5 The Safeguards apply to people across England and Wales who are living in institutions (either hospitals or care homes) and who lack capacity making them unable to consent to their care arrangements and treatment. This group of people includes individuals with dementia (the largest group), individuals with severe learning disabilities, those with mental health difficulties, as well as others who lack capacity, for example because of acquired brain injury.

1.6 A study undertaken in 2000 by the Department of Health concluded that of the 500,000 individuals around 50,000 (1 in10) would require restrictions to be put in place to safeguard them.

1.7 The Safeguards do not just apply to those being cared for by mental health or learning disability services. There is no difference between depriving a person who lacks capacity of their liberty for the purpose of treating them for a physical condition, for example a broken leg, and depriving them of their liberty for treatment of a mental health issue. Consequently, this Code of Practice must be followed and applied in acute hospital settings as well as care homes and mental health units.

1.8 The Safeguards relate only to people aged 18 and over. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered, particularly those under section 25 of the Children Act 1989. Similarly the Safeguards do not apply to individuals detained in hospital under the Mental Health Act 2003.

What is a Deprivation of Liberty?

1.9 The Code states that there is no simple definition of a deprivation of liberty, and whether an individual is deprived will depend on a combination of factors specific to their needs and circumstances. Court judgements that led to the introduction of the Safeguards have indicated factors that, when combined, may constitute a deprivation. Recent judgements regarding the use of the Safeguards have given further indications on how the legal system regards these factors and circumstances. Such factors include:

- The use of restraint, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercising complete and effective control over the care and movement of a person for a significant period.
- Staff exercising control over assessments, treatment, contacts and residence.
- The institution making a decision that the person will not be released into the care of others, or permitted to live elsewhere, unless staff consider it appropriate.
- The refusal of a request by carers for a person to be discharged to their care.

- The individual being unable to maintain social contacts because of restrictions placed on their access to other people.
- The individual losing autonomy because they are under continuous supervision and control.

When can someone be Deprived of their Liberty?

1.10 The Safeguards make it clear that a person should only be deprived of their liberty in circumstances when it is:

- In their own best interests to protect them from harm.
- A proportionate response to the likelihood and seriousness of the harm.
- If there is no less restrictive alternative.

1.11 The Safeguards allow for an authorisation of a deprivation of liberty to be granted after a series of independent assessments. A more detailed outline of the Safeguards can be found at **Appendix A** this is supported by a glossary of key terms at **Appendix B.**

Our role in Monitoring the Application of the Safeguards

1.12 The legislation introduced a duty for governments to monitor the implementation and operation of the Safeguards. In Wales, this duty fell on the Welsh Ministers and Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW) carry out these functions on their behalf. The requirements of monitoring and the expectations of how it will be taken forward are set out in Chapter 11 of the Code of Practice, including the requirement for an Annual Report.

1.13 We have worked with CSSIW to develop a joint approach to monitoring the operation of the Safeguards. Whilst we are producing individual reports to reflect the specific issues in health and social care, we have worked together to collect and analyse the relevant data.

1.14 Each Health Board (also known as the supervisory body) has been required to submit to us information in relation to every application received for authorisation to deprive an individual of their liberty. This included details of the characteristics of the individual for whom the application was made, information about the Safeguards process and the timing and outcome of applications.

1.15 Furthermore, health organisations across Wales who treat inpatients (NHS and independent hospitals) were also required to complete a qualitative survey designed to capture information about the systems and processes they have in place. We have used information gathered during our routine inspection activities to help us form a view on the effectiveness of these systems and processes.

Chapter 2: Applications for Authorisation

2.1 When a healthcare organisation **'*the managing authority*'** identifies the need to deprive an individual of their liberty due to it being in their best interest, they must make an application to their local health board (HB)[8] **'*the supervising authority'*** for an authorisation. The information that is required to be included in the application is clearly set out in the Code of Practice and for ease of reference is detailed at **Appendix A**.

2.2 There are two types of authorisation – an application for a **standard authorisation** is made when it appears likely that, at some time during the following 28 days, an individual will need to be cared for and/or treated in circumstances that would be considered to be a deprivation of liberty as defined by Article 5 of the European Convention on Human Rights. Whenever possible, authorisation must be obtained in advance of the circumstances leading to a deprivation being put in place.

2.3 Where time does not allow for a standard authorisation process to be followed, and it is believed that is in an individuals best interest to deprive them of their liberty, healthcare organisations must give themselves an **urgent authorisation** and then apply for a standard authorisation within seven calendar days.

2.4 In most cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. An urgent authorisation should only be required in exceptional circumstances.

2.5 In the following sections of this chapter we look at the number, type and outcome of the applications for authorisations made in the first year of the Safeguards being in place.

[8] Where an English Primary Care Trust (PCT) has commissioned the relevant care and treatment for an individual in Wales, the PCT will be the supervisory body. Similarly a health Board is the supervisory body for individuals from their area for whom they or the Health Commission Wales, commission care in a setting in England.

Number of Applications Made

2.6 Prior to the Safeguards being introduced an impact assessment[9] was undertaken by the Department of Health which estimated that approximately 500,000 people across England and Wales were living in institutions (either hospitals or care homes) who lacked capacity and were therefore unable to consent to their care arrangements and treatment. This group of people was considered to include individuals with dementia individuals with severe learning disabilities, those with mental health difficulties, as well as others who lack capacity, for example because of acquired brain injury.

2.7 A study undertaken in 2000 by the Department of Health concluded that of the 500,000 individuals around 50,000 (1 in10) would require restrictions to be put in place to safeguard them. Such restrictions, that might include preventing an individual from leaving the place in which they were being cared for, might amount to a deprivation of their liberty.

2.8 It was therefore estimated that in the first year of the Safeguards being in use there would be around 1,200 applications made across health and social care in Wales. Once a *'steady state'* had been reached it was believed that this figure would reduce to around 630 applications per year.

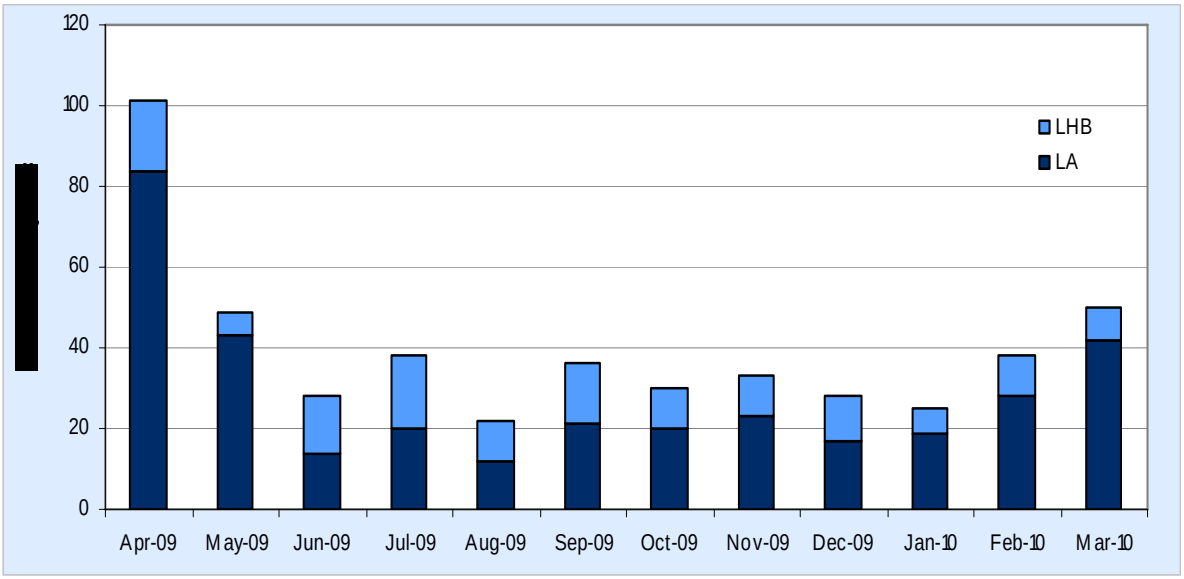
2.9 The actual number of applications made by health and social care organisations between April 2009 and March 2010 was **547** which was 44% less than expected. The total number of applications for assessment made to Health Boards was 135.

[9] Impact Assessment of the Mental Capacity Act 2005 deprivation of liberty safeguards to accompany the Code of Practice and regulations - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982

Comparison of the Number of Applications made by Health and Social Care Organisations

2.10 The number of applications made by healthcare organisations accounted for 25% of all applications made across Wales - see ***Chart 1 below.*** This percentage is in line with the planning assumptions made by Department of Health prior to the implementation of the safeguards.

Chart 1: Number of Applications made to Supervisory Bodies in Wales between April 2009 and March 2010



2.11 As can be seen from the above chart the rate of applications fluctuated over the year, although the monthly numbers of applications from healthcare organisations have been much more consistent than in social care.

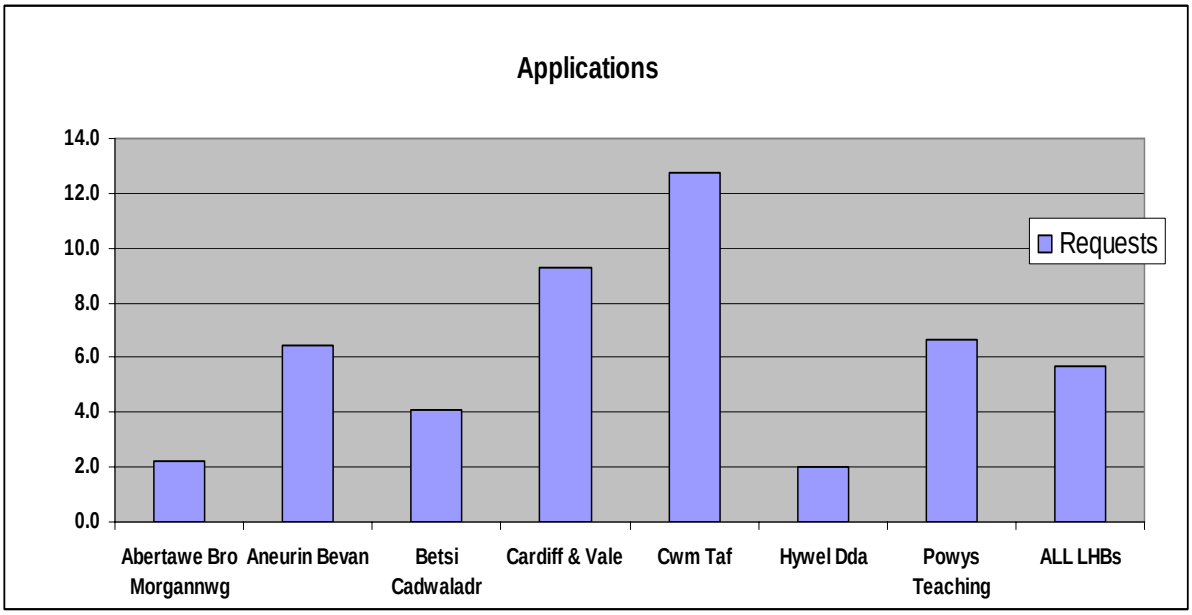
2.12 We found there to be little correlation between the number of applications made to Supervisory Bodies and population sizes or the types of settings within the Local Authority or HB area.

Comparison of Numbers of Applications made by Health Board (Supervisory Body) Area

2.13 The number of applications made varied across health board areas with the lowest being six in Hywel Dda HB and the highest 34, in Cardiff and the Vale University HB area.

2.14 The Cwm Taf HB area had the highest rate of applications when population is taken into account, with the rate of applications made being 12.8 per 100,000 and the Hywel Dda area the lowest at two per 100,000.

Chart 2: Application Rates per 100,000 Population



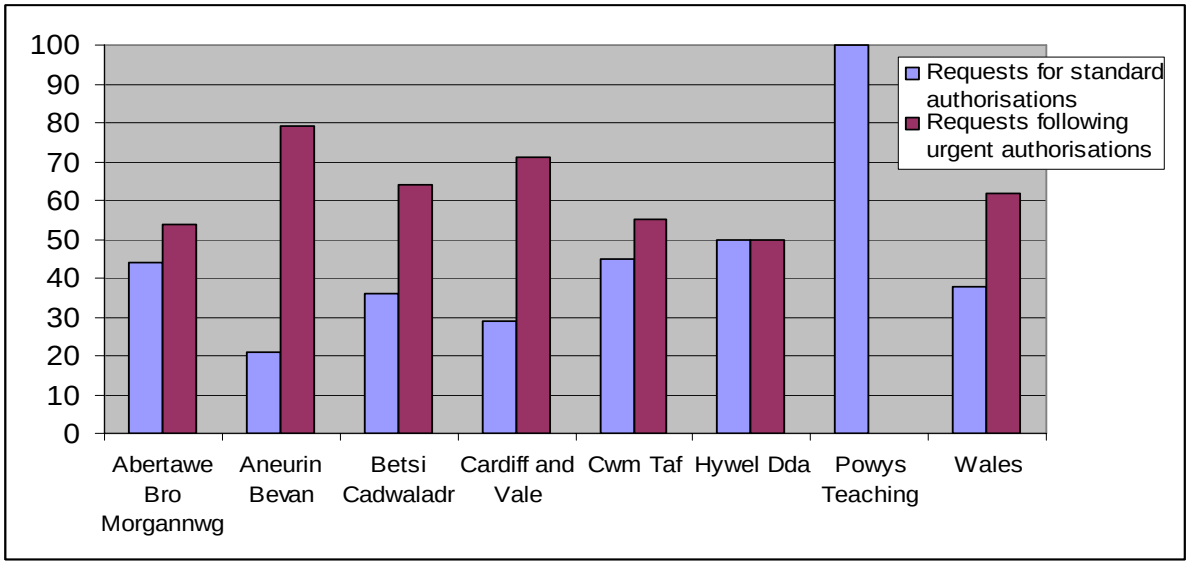
Number of Standard Applications made Compared to Urgent

2.15 In this first year **84** applications were made following an urgent authorisation, as shown in **Chart 3** below. Urgent applications therefore accounted for 62% of all applications made by healthcare organisations.

2.16 In each case a person was deprived of their liberty for the period until a decision was made about the application for a standard authorisation. This should be completed within seven days, although there is the ability to request that the supervisory body extend the urgent authorisation for a further seven days. Of the 84 urgent application 37 (44%) were not approved by the relevant health board.

2.17 As emphasised throughout this report, depriving someone of their liberty, unless it is in their best interest, is an infringement of the Human Rights Act. As the Code clearly states, with good planning urgent applications should be necessary only on rare occasions and where there is a risk that the restrictions placed on a vulnerable person constitute a deprivation of liberty.

Chart 3: Percentages of Applications Received for Standard Authorisations and Following Urgent Assessments Population

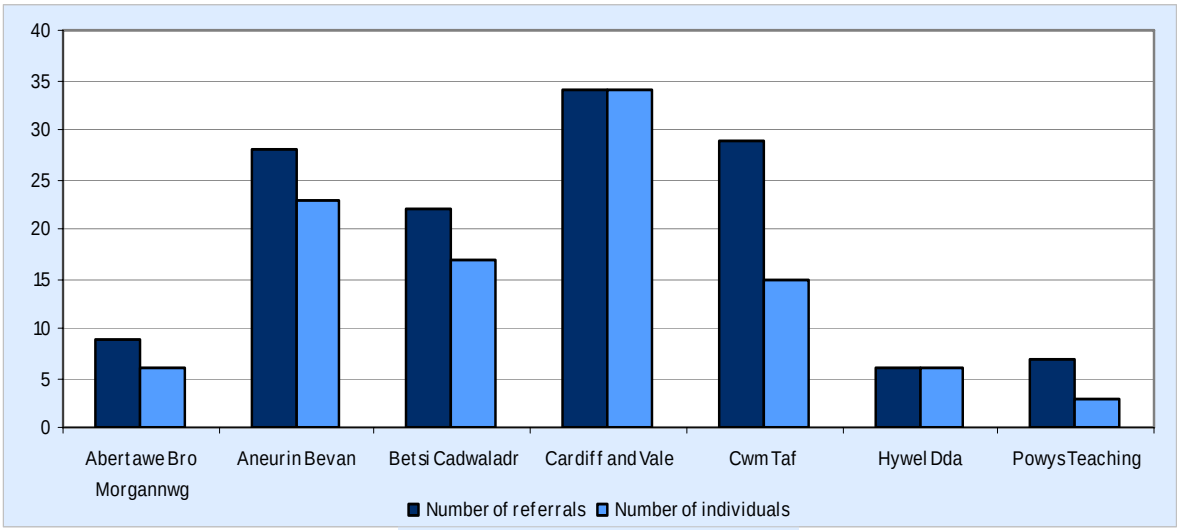


Number of Individuals for whom an Application was Made

2.18 An individual could be the subject of a number of applications during the year, for example if they were to move between hospitals or an authorisation was due to expire and needed to be extended.

2.19 From the data collected approximately 100 Welsh citizens residing in a healthcare setting (in Wales or England) were the subject of an application. A number of these individuals have also had applications made for them when they were residing in a care home.

Chart 4: Applications made and the Number of Individuals that these requests related to by Health Board (Supervisory Body)



2.20 During the year there were a small number of individuals from England who were receiving care in a hospital in Wales who have been the subject of an application. They will be accounted for in English monitoring data.

Characteristics of People for whom Applications were Made

2.21 The data supplied by supervisory bodies included information about the age, gender and ethnic group of people for whom applications were made. Total figures for the year show that:

- 72% of applications were for people aged 65 or over, with 23% for people aged 85 or over.
- 60% of applications were for women, with the proportion of women increasing as age increased.

- The proportion of applications received for people from each ethnic group was consistent with the make up of the population as a whole.
- Although the numbers for the smaller ethnic groups are too small to lead to statistically significant conclusions.

Applications made by Third Parties

2.22 A third party (such as a social worker, nurse or family member), rather than a hospital manager, can raise a concern that a deprivation of liberty may be taking place. Of the 135 applications made by health care organisations, around 1.6% were classed as third party requests. Those identified as making third party requests included advocates, social workers and solicitors acting on behalf of a patient or their family. They were concerned that a patient was being deprived of their liberty and so made a request to a Supervisory Body to examine the circumstances.

2.23 We found that most supervisory bodies had policies in place on how to manage third party requests, which were based on the Code. However, we consider that more needs to be done to raise the awareness and understanding of how they can make a third party referral when they have concerns.

Chapter Summary

2.24 While the number of applications made in 2009-2010 is small the figures highlight that there is some variation across health board areas in relation to the extent to which the new legislation is being used.

2.25 We are particularly concerned that the number of urgent applications made was far higher than estimated. As stated earlier in this report with good planning the number of urgent referrals should be minimal. Over the months ahead we will be working with healthcare organisations to get a better understanding of the reasons for this anomaly.

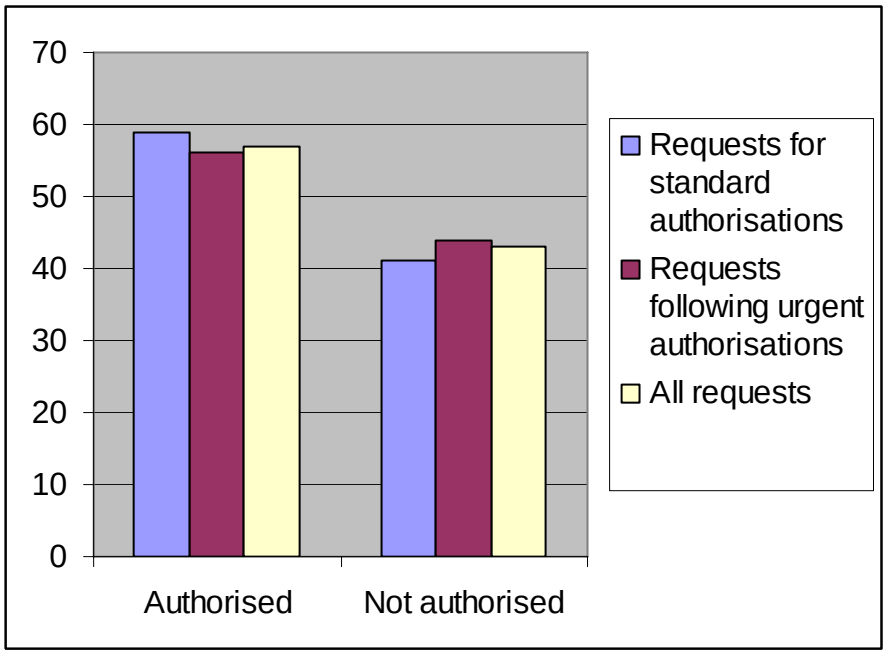
2.26 The level of variation and the number of urgent referrals suggest that there may be a training issue and that staff working in healthcare need to better understand what constitutes a deprivation of liberty.

Chapter 3: Authorisation of Applications

Number of Authorisations

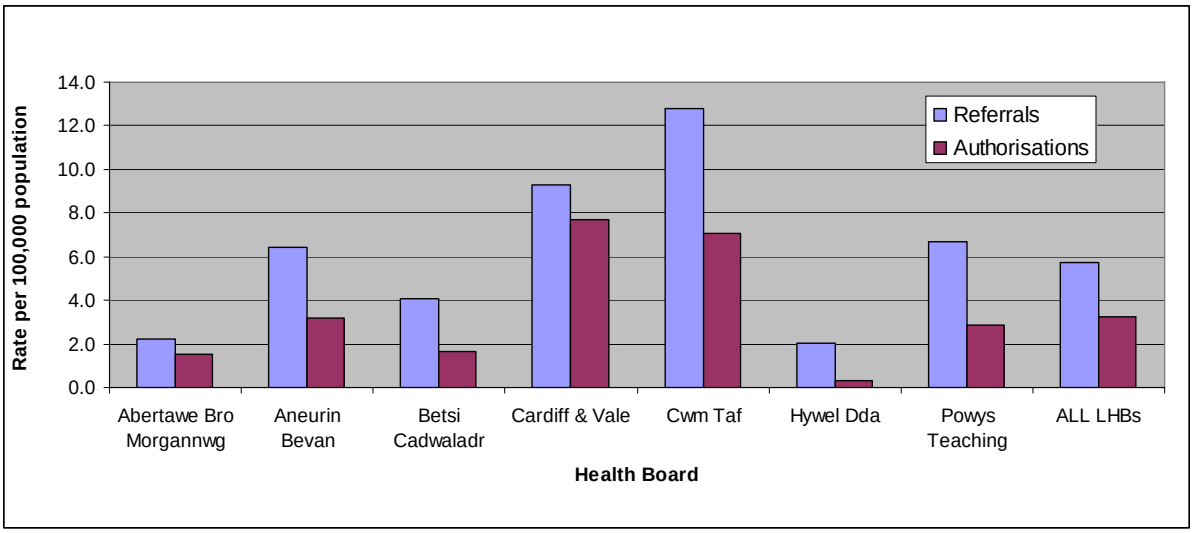
3.1 Of all the applications made (standard and urgent) during 2009-2010 57% (77) resulted in an authorisation being granted (see **Chart 5** below). This is a significantly higher proportion than expected. Prior to the implementation of the Safeguards planners expected less than a quarter of applications to result in an authorisation. However, this may be due to the total number of applications being much lower than expected.

Chart 5 Number of Applications Authorised Compared to those not Authorised



3.2 **Chart 6** demonstrates the variation in authorisation rates between health boards; it highlights that there is little correlation between authorisation and referral rates.

Chart 6: Rates of Referral and Authorisation per 100,000 Population



Reasons for Authorisations not being Authorised

3.3 Of the 58 (43%) applications not approved, the main reason for them not being approved was that the restrictions to be placed on the individual were considered to be not in the individuals' best interest, or alternatively the best interests assessor judged that no deprivation was occurring.

3.4 Further, in 7% of cases, it was concluded that the patient did in fact have capacity to make a decision about their situation, which indicates that knowledge and understanding of mental capacity may need strengthening within health and social care providers.

3.5 Out of the 58 applications that were not authorised, there were four cases identified where the person with responsibility for assessing the person's best interests judged that the person was being deprived of their liberty, and it was not in their best interests. Since the applications were not authorised, these people were at risk of being illegally deprived of their liberty, if they were not swiftly cared for or treated in less restrictive circumstances. In one case the patient was discharged before completion of all assessments and in the others the care plan was altered to reduce the restrictions on the individuals.

Application of Conditions

3.6 Once a decision has been made to approve an application, the best interests assessor can recommend conditions to be applied to the approval so that the interests and human rights of the individual are safeguarded as far as possible.

3.7 Conditions were applied to 90% (122) of all authorisations granted. Conditions applied fell into the following categories:

- A need to arrange the individual's discharge home or to an appropriate care setting.
- A requirement to arrange assessments to identify care needs such as occupational therapy or psychiatry.
- A requirement to put a financial package in place to support the individuals care needs in hospital, home or residential care.
- Requirements to ensure continued contact with specified individuals or to restrict such contact if in the individual's best interests.
- Describing appropriate levels of escort or supervision when on a ward or to facilitate access to the community.

Length of time for which Authorisations were Granted

3.8 Although an authorisation can last up to 12 months, we found that the majority had been approved for much shorter periods. In 43% of cases the authorisation was given for a period of 28 days or less, and in 91% of cases authorisation was given for three months or less. Only 1% of authorisations were for a period of over six months.

3.8 Of the authorisations that were granted, 62% (48) ran to the end of the period authorised and 32% (25) were terminated before their end date. The remainder were still in force at the end of the monitoring year.

3.10 The figures reflect the current philosophy that episodes of hospital care should be for as short a period as is necessary. What was less clear from the data was whether a number of individuals were the subject of repeated consecutive short term authorisations.

Timescales for Completion of Authorisation Process

3.11 There are specific timescales set out in the Safeguards for the completion of assessments, once an assessor has been instructed to take on a case. This is 21 days for a standard authorisation, but reduces to five days for assessments following an urgent assessment. In 2009-10, 60% of all applications were concluded in seven days or less, and 86% in less than 15 days. The high percentage of requests that follow urgent authorisations is placing a considerable burden on supervisory bodies, as they must meet the tighter timescales in many cases. The fact that in the majority of cases are completed within seven days of receipt is a credit to the efficiency of the supervisory bodies and their assessors.

Chapter Summary

3.12 We consider that the high percentage of approvals needs further investigation as does the large number of applications authorised that have required the setting of conditions. We will work with health boards to ensure these issues are fully explored.

3.13 It appears that the Safeguards are sometimes being used in situations where a patient is deemed as no longer in need of hospital care and thus is regarded as being *'detained'* as they are residing in hospital when they no longer need to be. There is some evidence to suggest that the Safeguards were maybe being used as a lever to facilitate discharge and to ensure that health and social care work together to ensure packages of care are expedited. This may account for the high use of urgent authorisations - again more work is needed to get a better understanding of this issue.

Chapter 4: Ensuring the Individual has a Voice

4.1 The Safeguards and the accompanying Code sets out a number of requirements that are centred upon ensuring that an individual who is subject to an application to have their liberty restricted is properly supported represented and hence has a voice. These are detailed below.

The Independent Mental Capacity Advocate (IMCA)

4.2 In undertaking a best interest assessment the health board must consult with a wide range of people including family, relatives and those who know the individual in a capacity other than a professional one. In circumstances when there is nobody appropriate to consult, other than people engaged in providing care or treatment to the individual in a professional capacity or for remuneration, the health board must then immediately instruct an IMCA, who is suitably qualified, to represent the person.

4.3 The IMCA's role in these circumstances is to familiarise him/herself with the individual's circumstances and consider what they may need to tell any of the assessors during the course of the assessment process. They will also need to consider whether they have any concerns about the outcome of the assessment process.

4.4 In circumstances where a difference of opinion between the IMCA and those undertaking the assessments on behalf of the health board cannot be resolved the IMCA can make an application to the Court of Protection. The IMCA can also challenge an urgent authorisation and again can refer the matter to the Court of Protection.

4.5 In the months ahead we will be working with health care organisations to collect detailed information on the appointment of IMCAs and the role they play.

Relevant Person's Representative or RPR

4.6 When an application is authorised, the Safeguards require the health board to appoint a relevant person's representative (RPR). Their role is:

- To maintain contact with the relevant person.
- To represent and support the relevant person in all matters relating to the deprivation of liberty safeguards including, if appropriate, the triggering of a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

4.7 The role of the RPR is crucial to ensuring that the individual is provided with the relevant independent representation and support. The appointed RPR does not have to agree with the deprivation of liberty.

4.8 To be eligible to be the relevant person's representative[10], a person must be:

- 18 years of age or over
- Able to keep in contact with the relevant person.
- Willing to be appointed.

4.9 The person must not be:

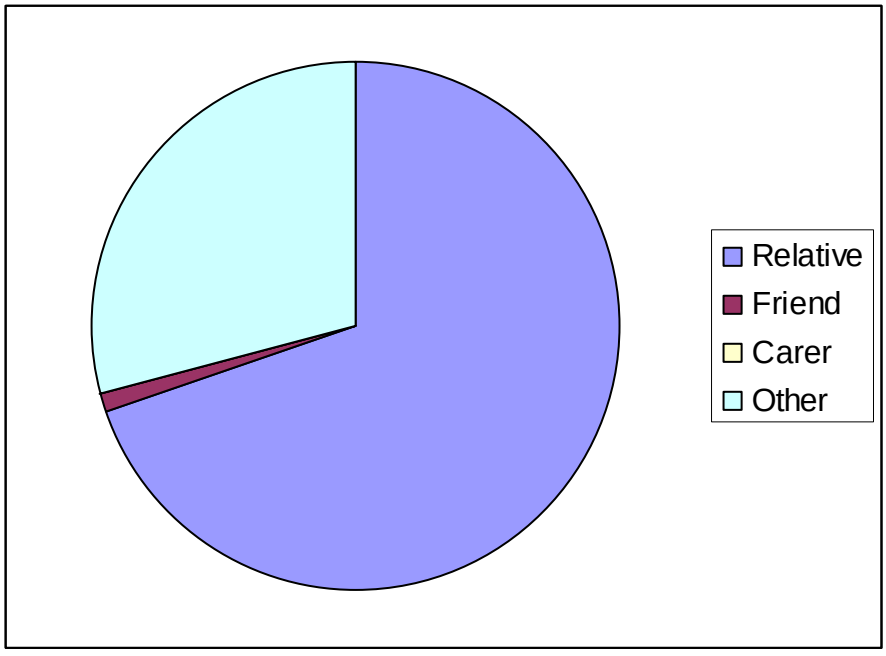
- Financially interested in the relevant person's managing authority (a person is considered to be financially interested where that person is a partner, director, other office-holder or major shareholder of the healthcare organisation applying for the deprivation of liberty).

[10] Requirements relating to the eligibility, selection and appointment of relevant person's representatives in Wales are covered in The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) (Wales) Regulations 2008.

- A relative of a person who has a financial interest in the relevant person's managing authority (paragraph 4.13 explains what is meant by *'relative'*).
- Employed by the hospital in a role that is, or could be, related to the treatment or care of the individual.
- Employed to work in the relevant person's supervisory body in a role that is, or could be, related to the relevant person's case.

4.10 Our review of data noted that RPRs had been appointed in all cases and highlighted that in the majority of the 77 cases authorised a relative had taken on the role of the RPR.

Chart 7 Details of the Individuals Undertaking the role of RPR



4.11 Generally, where RPRs were described as *'other'*, we found that the health board had appointed *'professional'* RPRs, for example, from Independent Mental Capacity Advocacy (IMCA) services established through the Mental Capacity Act or other advocacy services.

Payments to RPRs

4.12 The regulations that support the Safeguards in Wales allow for payments to be made to anyone fulfilling the role of an RPR to meet out of pocket expenses. It was disappointing to find that very few responses to our survey on RPR payment policies recognised that non-professionals (relatives, carers, friends) could and should be paid. It was clear from the data returned that payments had only been made to those professional organisations providing RPR services, through the extension of contracts or *'spot-purchasing'* of local advocacy services on an ad hoc basis.

Monitoring the Input of RPRs

4.13 Healthcare organisations (managing authorities) are responsible for monitoring the input of RPRs and for notifying the relevant supervisory body if there are any concerns. Most managing authorities were aware of this duty and many had either developed forms for recording contact or had expectations that contact was recorded in patients' notes. However, few organisations provided evidence of processes being in place to scrutinise records and follow up concerns.

4.14 A number of the responses submitted by independent hospitals only referred to advocacy services being available to patients in response to the questions asked about the RPR role.

Provision of Support to Non-Professional RPRs

4.15 The Code recognises that relatives, carers and friends acting as RPRs are likely to require help and support to understand their role and powers. Some managing authorities described supporting RPRs to understand their role, including inviting them to participate in care planning meetings. Health boards tended to provide a brief explanation that referred to the provision of leaflets or having the Best Interests Assessor explain the role during the assessment process.

4.16 Health boards have the option under section 39D of the Safeguards to appoint an IMCA to support a non-professional RPR. While the data collection did not gather specific information on the appointment of IMCAs in such circumstances, we have been told by IMCA providers that IMCA support has been inconsistently requested, with some making no requests.

4.17 We consider more needs to be done to support non-professional RPRs.

Requests for Review following Authorisation of Application

4.18 Once a standard authorisation has been given, managing authorities can ask for a review of the arrangements that have been put in place at any time. Similarly, the person subject to the deprivation and his/her RPR can request a review.

4.19 The number of requests for a review were surprisingly low with two patients being involved in requests made by the managing authority, six by the supervisory body and one by the relevant person's representative. It is unclear why this is the case. Such low numbers suggest that more needs to be done to encourage the relevant person and their representative to request regular reviews. Similarly, managing authorities should review their use of such procedures and evaluate whether they have used this process sufficiently and effectively.

Ensuring Welsh Patients Residing in Healthcare Organisations in England have access to Suitable Assessors

4.20 During the year, only one health board had received requests from English hospitals with regards to arranging assessments for Welsh patients. The health board put suitable arrangements in place, but highlighted to us their concerns that due to agreements in place in England they were paying a higher rate of fees to assessors than are paid across Wales.

4.21 More generally, discussions with practitioners have highlighted a lack of clarity around who can undertake assessments of Welsh patients when they are being cared for in England and vice versa. It is also unclear as to which regulations should be applied in relation to assessor background and training.

Chapter Summary

4.22 While health boards have complied with the Safeguards by ensuring that processes for the appointment of an IMCA or RPR are in place, more work is needed to ensure that non-professional RPRs are properly supported to fulfil the role both in terms of training and monetary support.

4.23 We are concerned that there have been only a few requests made for a review following an authorisation being granted. More needs to be done by health organisations to ensure the right to request a review is properly publicised and individuals subject to an authorisation, carers, relatives and staff are empowered and supported to make such requests.

Chapter 5: Organisational Arrangements to Support Compliance with the Safeguards

Organisational Awareness

5.1 We issued a questionnaire to all healthcare organisations across Wales (NHS and independent) to gather information on the systems and processes they have place to ensure compliance with the Safeguards as a supervisory body and/or managing authority, and to test their awareness of their role in ensuring compliance. We received responses from all NHS organisations and 60% of independent hospitals. We will be visiting those independent hospitals who did not respond to ensure that they have the appropriate mechanisms in place.

5.2 We found most organisations to be aware of their responsibilities and to be clear that there could be circumstances when the Safeguards would be applicable to them. One independent Mental Health hospital did however consider the Safeguards not to be applicable to them as they only admitted detained patients. The organisation had not considered circumstances when a detention can suddenly no longer apply, whether due to a Court or Tribunal decision or lapse in due process, but the patient remains informally at the hospital in circumstances that could be a deprivation of liberty. We will be following this matter up with the organisation to ensure that the issue is addressed.

Management and Oversight Arrangements

5.3 A variety of arrangements for the management and oversight of the Safeguards have been put in place. In some regions of Wales consortia have been developed between health and social care organisations to deliver supervisory body functions. Where such arrangements are in place the organisations involved found them to be advantageous particularly in relation to developing a pool of assessors who could work across health and social care organisations. In addition such

arrangements enable assessments to be re-used under equivalency regulations, for example when a patient with a short term hospital authorisation is moved into a care home.

5.4 It is important however that the individual organisations involved in such consortia arrangements do not lose sight of their individual accountabilities and responsibilities.

5.5 The Code highlights the need for managing authorities and health boards to monitor and audit the use of the Safeguards by their organisation. When responding to our questionnaire, few organisations referred to monitoring arrangements being in place at a senior or strategic level in their organisation.

5.6 Some independent hospitals did have clear clinical governance processes in place for the reporting of applications made under the Safeguards to their parent organisation. However, for many NHS organisations the link to clinical governance structures was not always that clear, which was demonstrated by the lack of reference to the Safeguards in many NHS organisations annual Healthcare Standards self-assessments. Some practice worthy of note is the inclusion of an item on the Safeguards as a standing item on the medical director's monthly report to the Board, which has been put in place by Betsi Cadwaladr Health Board.

Ensuring Separation of Roles of Managing Authorities and Supervisory Bodies

5.7 The restructuring of the NHS that occurred in October 2009 resulted, for these bodies, in the roles of managing authority and supervisory body being brought into one organisation. Guidance[11] issued by the Welsh Assembly Government make it clear that there should be a separation between the two roles so that any potential conflict of interest is avoided. However, we found that a number of health boards had not updated their policies since the new structures came into being and as a consequence there was a lack of clarity in relation to who was responsible for some activities.

5.8 Some of the changes have resulted in anomalies that need to be addressed, for example Abertawe Bro Morgannwg University Health Board has inherited the supervisory authority responsibilities of three former Local Health Boards. Two had developed a joint team to administer the Safeguards which worked purely across health while the third had a joint arrangement with its respective local authority. These arrangements have continued after the new organisation came into being, leaving the health board with two teams and sets of arrangements in place, some involving social care and some not.

5.9 A number of health boards have taken specific steps to ensure a clear separation of the two roles, for example they have put in place:

- Arrangements where there is a different executive lead for each function.
- Separate sources of legal advice for those carrying out each function.
- Administrative arrangements with one staff member responsible for making requests and arranging internal training and another for administering them.

11 Guidance for Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards, February 2009.
http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=744&id=115871

5.10 However, the separation of functions is not always clear at an administrative level, with Safeguards co-ordinators sometimes having the role of administrator of requests, provider of advice in relation to individual cases and providers of training to staff in hospitals and care homes in the area. Such arrangements could give rise to a potential conflict of interest or lead to applications likely to fail being inappropriately screened out. In some organisations the same staff also undertake audits of managing authority functions.

Policies and Procedures

5.11 All health boards had policies in place for the administration of the Safeguards, some of which had been developed jointly by health and social care partners. However, a number of health boards had not amended or formally adopted these policies since the restructuring of the NHS that took place in October 2009.

5.12 While policies and procedures clearly demonstrate an understanding of the role that health boards play, they do not always clearly set out some of the practicalities of administration, for example it was not always clear as to what grade of staff had been delegated responsibility for signing off authorisations on behalf of the health board.

5.13 Issues were raised with us in relation to timescales, particularly for the completion of standard authorisations where urgent authorisations are in place. The legislation gives no indication as to when the clock should start and stop, unlike the Mental Health Act which is clear on timescales. Concerns that the timescales included non-working days including weekends and bank holidays were also raised with us.

5.14 While we appreciate the concerns, particularly as the much higher than expected use of urgent authorisations has placed a heavier burden on supervisory bodies it must be acknowledged that the Safeguards apply every day of the year. It is the responsibility of all health care organisations to ensure that they have appropriate arrangements in place to manage timescales and the volume of applications.

Forms and Guidance

5.15 It was clear that health boards welcomed the additional guidance issued by the Welsh Assembly Government; this was noticeably used as the basis of many policies and procedures submitted to us. Unlike the Mental Health Act there are no prescribed statutory forms, although the Welsh Assembly Government has produced model forms and letters.

5.16 We are aware of discussions amongst practitioners regarding the usefulness and appropriateness of their format. While it is for health care organisations to work with the Welsh Assembly Government to agree a format that is more user friendly. Whatever is agreed must fulfil all legal requirements relating to the information to be included in applications, records and notifications.

Training and Support for Staff

5.17 Most organisations had put a variety of training activities in place in preparation for the introduction of the Safeguards, including:

- Awareness training for ward managers.
- Inclusion of the Safeguards in the mandatory training programme.
- A tiered system of training for managers, decision makers and ward staff.
- Targeted training for managers and clinicians, rehabilitation and medical wards and transfer and discharge liaison nurses.
- DVDs and e-learning packages.

5.18 However, some organisations told us that they had experienced difficulties in getting clinicians to engage in the agenda. This reflects the findings that have arisen form our dignity and respect visits. We found that understanding of and engagement with the Mental Capacity Act is not always as good as it should be amongst clinicians, neither is there widespread understanding of the implications that the Act has on professional practice or the risk that non-compliance with the Act brings to the organisation.

5.19 A few organisations have developed tools to support staff to recognise a situation that could give rise to a deprivation of liberty. These include capacity checklists and assessment tools as well as posters and flowcharts. In certain organisations named members of staff have been identified as points of contact to provide guidance and support when needed. Others have established processes for multi-disciplinary discussions or reflective review of individual cases, so that lessons can be learned and improvements made to practice.

Patient Information

5.20 Most organisations had developed leaflets and information packs for patients, carers and relatives. However, the approach taken and content of information was inconsistent.

5.21 It is clear from for example, the figures relating to requests for reviews and the low number of payments made to non-professional RPRs that there is a lack of knowledge and awareness of certain aspects of the Safeguards and accompanying code. We therefore believe that the introduction of a standard information pack that could be used by all Welsh healthcare organisations would be extremely useful and ensure that the right information was provided to patients, carers and relatives in a timely fashion.

Appointment of Assessors

5.22 As referred to earlier in this report health boards have a responsibility to appoint assessors who meet the eligibility requirements laid out in regulations and who have the suitable skills and knowledge to assess the particular individual's case. It is important that the staff who undertake assessments have been properly trained and are competent to fulfil the role.

5.23 In our survey we gathered information on the professional background of individuals appointed by health boards to undertake the six statutory assessments that are required by the Safeguards (see Appendix A). The table below summarises our findings:

Assessment	Background of those Appointed to Assess
Age	Supervisory bodies used a mix of Approved Mental Health Professionals[12] (AMHPs), social worker and nurses.
Best Interests	This was equally mixed between AMHPs, social workers, general and mental health nurses. They were generally selected for their experience in carrying out assessments of care needs, such as for continuing healthcare funding.
Capacity	Almost all supervisory bodies made use of section 12 doctors;[13] around half also used AMHPs, social workers, nurses or other doctors.
Eligibility	All supervisory bodies used section 12 doctors, with just under half also using AMHPs and a few other doctors or mental health nurses. This choice was mainly as such staff should understand eligibility for detention under the Mental Health Act and can judge which legal framework is the correct one to use.
Mental Health	These assessments were almost always carried out by Section 12 doctors.
No Refusals	Supervisory Bodies used a mix of AMHPs, social worker and nurses.

[12] A professional with training in the use of the Mental Health Act approved by a Local Social Services Authority to undertake a number of functions under the Act – can be a social worker, nurse, psychologist or occupational therapist.

[13] A doctor who has been approved by the Welsh Ministers, or on their behalf, under the Mental Health Act as having special experience in the diagnosis or treatment of mental disorder. Some medical recommendations and medical evidence to courts under the Mental Health Act can only be made by a doctor who is approved under section 12.

5.24 We are aware that some health boards have only a small pool of assessors in place. While this ensures that assessors use their skills regularly and develop expertise, potentially assessors may not have sufficient knowledge to suit the circumstances of the patient. Also where there is a small pool, it is possible that the views and understanding of a few influence the general application of the Safeguards in an area, for example in determining what constitutes a deprivation or a restriction.

Training and Support for Assessors

5.25 Supervisory bodies have a duty to ensure their assessors have the skills and competencies to undertake this work. Most of the assessor training and support activity reported to us focused on the Best Interest Assessors (BIAs). This is not surprising, as they have a wide range of responsibilities to undertake including determining whether a deprivation is occurring, determining best interests, setting conditions and recommending RPRs.

5.26 As well as providing training for their BIAs most health boards have put support mechanisms in place such as peer support, formal supervision and practice groups that meet to discuss issues, cases and receive updates on the emerging case law. As a consequence of the low levels of usage of the Safeguards some assessors have had few or no opportunities to undertake assessments during the year and have found such updates invaluable in keeping up their knowledge and confidence levels.

5.27 In Wales, BIAs are not required to be accredited following training. In healthcare we have found high levels of interest from supervisory bodies in obtaining accreditation for their BIAs. There is a need for further debate in taking this forward in Wales. Consistent standards of training which are verified through accreditation would give more robust assurance about the baseline of skills and knowledge that assessors bring to the task.

Ensuring all those who should be Involved are Involved in Assessments

5.28 Health boards as supervisory bodies have a duty to ensure that all relevant people are consulted with and involved in the assessments required by the Safeguards. Most health boards told us that they ensure that all relevant people are involved by reminding assessors of this requirement during training. We believe that a more robust approach is needed to ensure that this happens routinely in practice.

5.29 Some health boards had scrutiny processes in place. For example – across Cwm Taf health board all authorisations are scrutinised by an executive officer who checks to ensure that all relevant people have been consulted and involved. The health board also uses information available to their joint health and social care team to identify any previous contact the patient may have had with services. From this information the health board is able to identify any relatives and professionals involved in the individual's care and who should be contacted to ensure their involvement in the assessment process. We consider this to be noteworthy practice.

Chapter Summary

5.30 While procedures and processes are in place more work is needed to strengthen them and to ensure there is absolute clarity in relation to roles, responsibilities, processes and their application. We are concerned that in many healthcare organisations there appears to be an insufficient corporate engagement with the Safeguards and a lack of understanding of the implications for the organisation if they don't comply with the requirements set out in legislation and the Code.

5.31 The Safeguards framework bestows on health care organisations powers and responsibilities that could have serious human rights, legal and reputational risks should they not follow due process. It is therefore imperative that health boards and

other managing authorities manage and operate these Safeguards and the wider requirements of the Mental Capacity Act appropriately in order to protect some of the most vulnerable of our society.

5.32 We will be following our concerns up with health organisations as part of our routine inspection work and will ensure action plans are put in place to address the gaps and weaknesses we have highlighted.

Chapter 6: Conclusions and next Steps

6.1 Our analysis of the data and information returned by healthcare organisations provides some interesting information about the way in which the Safeguards have been implemented in this first year.

6.2 Although a great deal has been achieved in this first year and some clarity has developed around the benefits the Safeguards can bring to individuals, it is clear that public understanding of the Mental Capacity Act and its Safeguards is under-developed. The Mental Capacity Act highlights the value of planning ahead, so that people make choices when they have capacity that can inform decisions should their capacity become be impaired later on. People can only benefit from the Safeguards if they are aware of them and guidance is made clear.

6.3 The variability of practice highlighted in this report must be properly evaluated by healthcare organisations. They need to ensure that all staff understand and properly apply the Safeguards and the Mental Capacity Act more generally. It must be understood that the Safeguards affect all who work in the health sector, not just those who specialise in providing care and treatment to those with for example a mental health issue or learning disability.

6.4 Over the year ahead we will continue to monitor the application of the Safeguards as a matter of routine and the information gathered in this first year will be used to inform the further development of our approach. We will also be working closely with those organisations where we have identified specific issues and concerns. We will require them to prepare action plans and report to us regularly on their progress in taking actions forward.

6.5 A final point to note is that we have found that the Safeguards are considered to be less stigmatising, less restrictive and preferable to detention under the Mental Health Act. We would remind practitioners that both legal frameworks are there to authorise the detention of someone and can enable the use of considerable

restrictions on a person. One of the first important pieces of case law[14] around the Safeguards to have come out of the Court of the Protection clearly indicates that the starting point for considering whether to deprive a patient of their liberty should be whether the patient can be detained under the Mental Health Act. If so, authorisation for detention should be sought through this framework. Professionals cannot pick and choose between the two regimes as they wish.

[14] GJ v The Foundation Trust (2009) EWHC 2972 (Fam)

Appendix A

What are the Deprivation of Liberty Safeguards and why were they Introduced?

These Safeguards are an integral part of the Mental Capacity Act 2005 although they were introduced as an amendment under the Mental Health Act in 2007 and designed to remedy incompatibility between English law and the European Convention on Human Rights. The Mental Capacity Act has to be understood before the Deprivation of Liberty Safeguards can be considered.

The Mental Capacity Act provides a statutory framework to recognise, empower and protect vulnerable people who are not able to make their own decisions without assistance. The Mental Capacity Act makes clear how people may be supported to make decisions and how decisions may be taken on behalf of people who lack capacity permanently. It enables people who have capacity to plan ahead for a time when they may lose capacity.

The Mental Capacity Act is based on five principles:

- A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests – anything done for or on behalf of people without capacity must be in their best interests.
- Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

These principles also underpin the Deprivation of Liberty Safeguards (DoLS). The Safeguards provide a legal framework which prevents arbitrary decision-making. They can only apply where an individual has a mental disorder including learning disabilities and lacks the capacity to consent to the arrangements made for their care or treatment. To be lawful, the circumstances of this care or treatment must amount to a deprivation of their liberty within a care home or hospital and, following assessment must be in their best interests. It must also be a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm. Full consideration has to be given to other less restrictive alternatives before a deprivation can be authorised.

The Safeguards place duties on a hospital or care home, known as the managing authority in this legislation. When the managing authority identifies that it is, or soon will be, depriving a resident or in-patient who lacks capacity of their liberty, they must apply for authorisation of the deprivation. This may be given by the relevant supervisory body (health boards and local authorities) following assessment against six criteria.

The criteria are defined fully in legislation and the DoLS Code of Practice. In summary:

- Age (the person must be aged 18 years or over).
- Mental Capacity (does the person have the capacity at this time to decide whether or not they should be accommodated in a care home or hospital to be given care or treatment?).
- Mental Health (has the person a mental disorder as defined in the Mental Health Act, or a learning disability?).
- Eligibility (would the authorisation conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983?).
- No Refusals (is there any other existing authority for decision making for the person that would prevent an authorisation, for example a valid advance decision to refuse treatment).

- Best Interests (is a deprivation of liberty occurring, and if so, is it in the person's best interests?).

An assessment has to be made against each criterion and must take place within specific timescales. Supervisory Bodies should ensure that assessments for standard authorisation are completed within 21 days. Where a managing authority identifies that a deprivation of liberty is already occurring, it may grant itself an urgent authorisation which can last for seven days. The managing authority must in all circumstances apply for a standard authorisation at the same time from the relevant supervisory body. Standard authorisation assessments must take place within seven days, or in exceptional circumstances, 14 days if an extension is applied for by the managing authority and granted by the supervisory body.

All assessments can be undertaken by the same assessor except the Mental Health assessment and the Best Interests assessment which must be made by two different assessors. (Their specific qualifications and training are set out in the Welsh regulations and neither can be involved in providing care or in making other decisions about the person's care). The Best Interests Assessor (BIA) will establish whether the least restrictive alternatives have been considered and whether there is or should be a deprivation of liberty. If so, the BIA will consider whether it is:

- In the best interests of the person.
- Necessary to prevent them coming to harm.
- A proportionate response to the likelihood of them suffering harm and the seriousness of that harm.

If all six assessments apply, then the supervisory body must issue a standard authorisation to the managing authority. It can place conditions on this and limit its length. No authorisation can last more than 12 months, and cannot be renewed. When an authorisation ends, for any reason, the person must cease to be deprived of their liberty immediately. However, a new authorisation can be made to run consecutively.

If assessors decide that any of the six criteria do not apply, then the authorisation cannot be granted.

As part of the authorisation, the supervisory body must appoint a Relevant Person's Representative (RPR) who will maintain contact with the relevant person. They must represent and support them in all matters relating to the safeguards such as triggering a review or using an organisation's complaints process. The managing authority should monitor that this happens and inform the supervisory body if it does not. They can also ask the supervisory body for a review when circumstances change.

Independent Mental Capacity Advocates

The DoLS Code of Practice prescribes when an Independent Mental Capacity Advocate (IMCA) should be instructed. IMCAs have roles and responsibilities within the Mental Capacity Act as a whole, but have additional rights and responsibilities when instructed under the safeguards process. IMCAs in this context have the right to:

- "*as they consider appropriate, give information or make submissions to assessors, which assessors must take into account in carrying out their assessments,*
- *receive copies of any assessments from the supervisory body,*
- *receive a copy of any standard authorisation given by the supervisory body,*
- *be notified by the supervisory body if they are unable to give a standard authorisation because one or more of the deprivation of liberty assessments did not meet the qualifying requirements,*
- *receive a copy of any urgent authorisation from the managing authority,*
- *receive from the managing authority a copy of any notice declining to extend the duration of an urgent authorisation,*
- *receive from the supervisory body a copy of any notice that an urgent authorisation has ceased to be in force, and*

- *apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with a matter relating to the giving or refusal of a standard or urgent authorisation (in the same way and any other third party can).”*

Appendix B

Key Terms used in the DoLS Annual Report

The table below is not a full index or glossary. Instead, it is a list of key terms used in this Annual Report. Where necessary it may expand on particularly important tasks carried out by significant people.

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Approved mental health professional	A social worker or other professional approved by a social services authority to carry out a variety of functions under the Mental health Act, 1983. Previously this role was called an Approved Social Worker (ASW).
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments must be positive for an authorisation to be granted.
• Age assessment	An assessment of whether the relevant person has reached age 18.
• Best interests assessment	An assessment of whether deprivation of liberty is in a detained 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 lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care hone 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 individual (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.

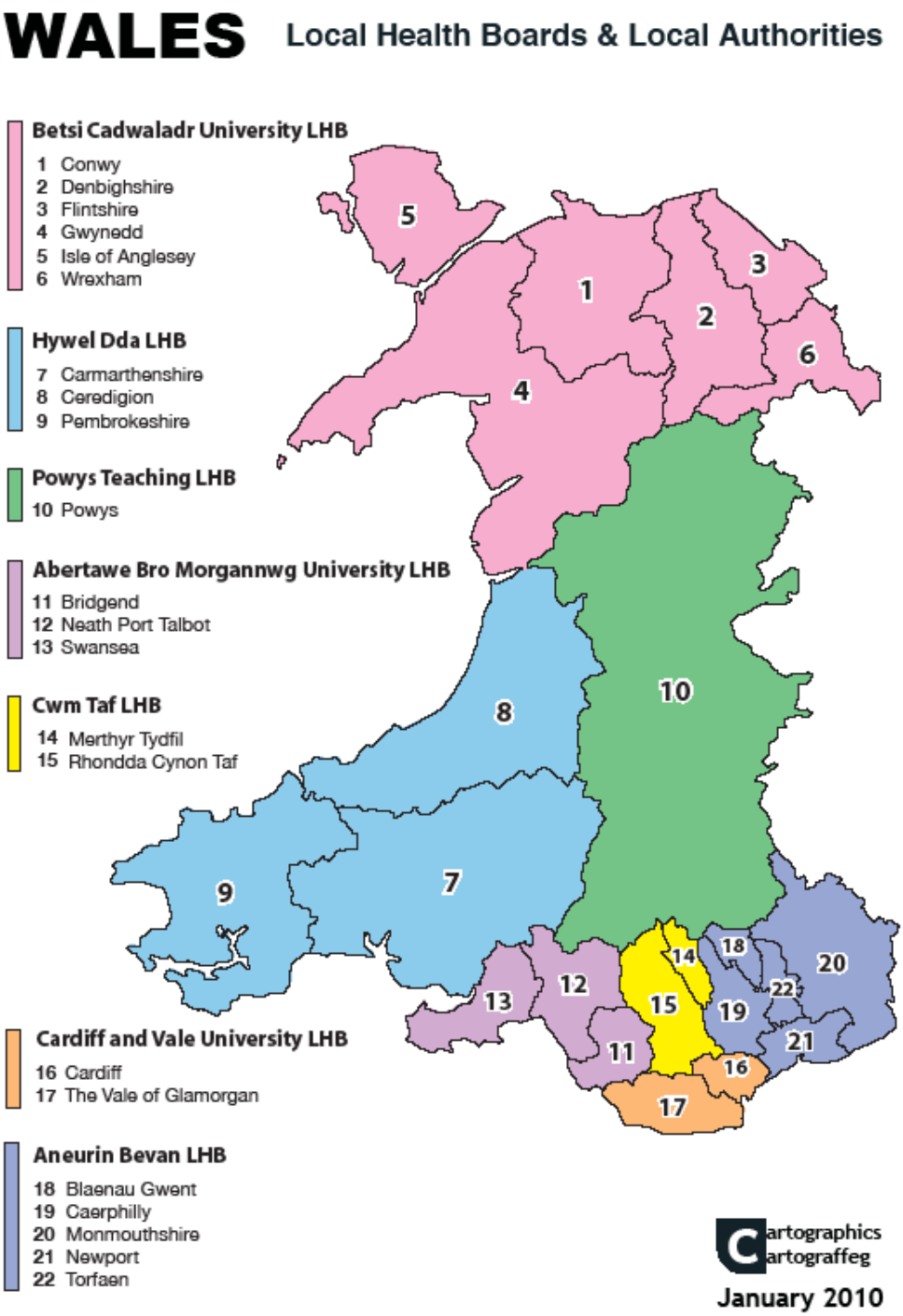
Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
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	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability. In this report the term carer does not mean a paid care worker.
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 capacity to make specific decisions.
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	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.
Deprivation of liberty safeguards assessment	Any one of the six assessments that need to be undertaken as part of the standard deprivation of liberty authorisation process.
Guardianship under the Mental Health Act 1983	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local authority or a private individual approved by the local authority.

Health Board	Health Boards fulfil the supervisory body function for health care services and work alongside their respective local authorities in planning long-term strategies for dealing with issues of health and well-being.
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 a health service hospital as defined, 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)	Someone 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.
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 where someone appoints an attorney (donee) or attorneys, to make decisions about their personal welfare, including health care, and/or deal with their property and affairs.
Local Authority	In the deprivation of liberties context, the local council responsible for social services in any particular area of the country. Social services fulfil the supervisory body function for social care services.
Managing authority	The person or body with management responsibility for the 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 must not exceed the period recommended by the best interests assessor, and which cannot be for more than 12 months.
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 covers 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 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 relevant hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person 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.
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 the relevant 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 request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
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, that 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 C

Map of Wales Showing Location of Supervisory Bodies (Local Authority Social Services and Health Boards)



Appendix D

List of Relevant Guidance and Information

Documents Published to Support Understanding of the Safeguards:

Mental Capacity Act, 2005 – Code of Practice,
Issued by the Lord Chancellor on 23rd April 2007 in accordance with sections 42 and 43 of the Act

Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, Laid before Parliament by the Ministry of Justice

Mental Health Act 1983 Code of Practice for Wales
Issued by the Welsh Assembly Government 2008

Guidance to Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Standard forms and letters for the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Mental Capacity (Deprivation of Liberty: Appointment of Relevant person's Representative) (Wales) Regulations 2009

Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about residence) (Wales) Regulations 2009

Other documents which were considered when compiling the Annual Report:

Impact Assessment of the Mental Capacity Act 2005 (Deprivation of Liberty: Monitoring and Reporting; and Assessments)
Department of Health

The Mental Capacity Act 2005, Deprivation of Liberty Safeguards – the early picture
Issued by the Department of Health

Statistics produced by the NHS Information Centre