Meeting Date	**05 November 2020**	**Agenda Item**	**3.1**
Report Title	Update position on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), for Quarters 1 and 2 2020		
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Report Sponsor	Christine Williams Interim Executive Director of Nursing		
Presented by	Tanya Spriggs Interim Unit Nurse Director Primary and Community Service Delivery Unit		
Freedom of Information	Closed		
Purpose of the Report	To provide an update and assurance around the management of Deprivation of Liberty Safeguards (DoLS)		
Key Issues	• Performance in quarters 1 and 2, including breaches. • Completion of all Internal Audit recommendations. • The implications of COVID19 and ward visiting restrictions • New Liberty Protection Safeguards (LPS) legislation will be replacing DoLS, these changes have been postponed to April 2022.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to note : 1. Performance data for Qtr 1 April to 30 June 2020 (Appendix 1). Qtr 2 July to 30 Sept 2020 (Appendix 2)

	2. Further LPS guidance has been delayed due to the COVID-19 pandemic. The new implementation date, has been confirmed as April 2022. 3. The COVID pressures and impact on management of DoLS applications (Appendix 3) 4. The impact of COVID on management capacity to develop a business case for a new DoLS service to fully meet Health Board requirements (Appendix 4)
	 Appendix 1 - DoLS Referral Data Qtr 1.c  Appendix 2 - DoLS Referral Data Qtr 2.c  Appendix 3 SBAR Current DoLS Service  Appendix 4 SBAR DoLS Service Model.

Update position on Deprivation of Liberty Safeguards and MCA

1. INTRODUCTION

The purpose of this report is to provide an update on Quarters 1 and 2 in relation to Deprivation of Liberty Safeguards (**Appendix 1 & 2**) together and MCA.

2. BACKGROUND

The Mental Capacity Act, Deprivation of Liberty Safeguards provides a legal framework to protect **vulnerable adults,** who may become, or are being deprived of their liberty in a **care home** or **hospital setting.** These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their **best interests,** other than under the Mental Health Act 1983 (MCA Code of Practice). The safeguards came into force in Wales and England on the 1st April 2009.

The Mental Capacity Act 2005 (MCA) came into force in October 2007, SBU HB supports a significant number of patients with impaired decision-making, therefore this report aims to provide assurance of awareness and the use of MCA throughout the Health Board, via training and the use of the Independent Mental Capacity Advocacy Service (IMCAs).

3. GOVERNANCE AND RISK ISSUES

To enable the Primary and Community Services Delivery Unit to discharge their functions as the Supervisory Body the following actions have been completed.

Internal Audit Action Plan

The DoLS Team and Improvement Group have continued to work on and completed actions as identified in the internal audit. The audit has lifted the level of assurance from Limited Assurance to Reasonable Assurance and reflects the level of improvement work undertaken by the team. At time of reporting, all actions are complete.

Referrals

In Q1 there were 176 referrals received, of those 54 were assessed by the 2 dedicated BIAs, the internal (not primary role) BIA's did not complete any assessments and the external BIAs assessed 1 resulting in 38 being granted (**Appendix 1**)

In Q2 - 177 referrals were received, of those 48 were assessed by the SBU HB dedicated BIAs, of which 22 were granted, with 8 awaiting completion with 18 not granted as patients were either discharged/not a deprivation or died. (**Appendix 2**)

The internal (not primary role) BIA's have not completed any assessments.

The external BIA's assessed 22 of which 15 were granted, with 5 awaiting completion with 2 not granted as patients were either discharged/not a deprivation or died.

Breaches are recorded in accordance with Welsh government guidance – the legislative time frame for assessors to complete the assessments does not start until 2nd assessor has been allocated - breach occurs if the urgent is not completed in 5 days of allocation; standard 21 days – we do not include 'breaches' between lapse of an urgent to point when standard is authorised
It is important to note that figures for activity in each quarter will not equate as some assessments would have been received in the previous quarter , while some assessments whilst allocated will not be authorised until following quarter.

Activity performance had only marginally improved throughout the year, compared to the same period last year which was due to the overall lack of capacity from the internal BIA resource (Appendix 3). If the Heath Board is unable to undertake timely completion of DoLS authorisations the Health Board will be in breach of legislation and claims may be persued as a result. This is noted both on the Copropate Risk Register and the PCT Group Risk Register with a score of 16.

The cumulative number of discharges for the first quarter is 177, whilst in second quarter it is 64 – (this figure includes discharges, death, further assessments, reviews of conditions, patients not meeting DoLS criteria therefore DoLS applications are stopped).

Although the number of breaches are greatly reduced, most breaches are due to a continuing lack of BIA Assessors and COVID restrictions. This has been discussed in previous papers, however the situation is further compounded due to COVID 19.

The existing plan was to reduce the reliance on the externally contracted BIA roles and use internal Health Board BIA's who are currently employed in substantive roles within Service Delivery Units. This model has been challenging due to staffing pressures throughout the COVID period. The Delivery Units have not been able to release staff particularly during winter pressures and the COVID 19 period. The internal BIAs were allocated 2 days a month but have not been released to the Supervisory Body to deliver the required functions due to COVID-19. This results in the Supervisory Body having to fund external BIA's, however, this is insufficient to deliver all assessments within the required time scales. In order to prepare and deliver on the LPS agenda a lead 8a role to encompass LPS and MCA will be explored.

Discussions have taken place with corporate nursing colleagues, and whilst all acknowledge the need to develop a business case around DoLS and MCA,

COVID 19, has adversely impacted on management time to progress. However, we will look to progress the business case in the latter part of quarter 4. An SBAR report is included(**Appendix 4**)

DoLS Training:

All face-to-face DoLS training was suspended in March 2020, due to COVID-19. Training was recommenced in virtually in September 2020.

BIA's have linked with Corporate trainers in Swansea University following feedback received from MA's and the training has been amended to incorporate links between theory to practice in an aim to increase staff confidence and improve standards in practice.

BIA's have continued to provide additional support in terms of workshops across SBUHB.

MCA Training

MCA Level 1 & 2 training continues to be delivered via e-learning for all SBU HB staff. MCA Level 3 training is facilitated as a workshop directed at ward managers, senior nurses and senior clinicians.

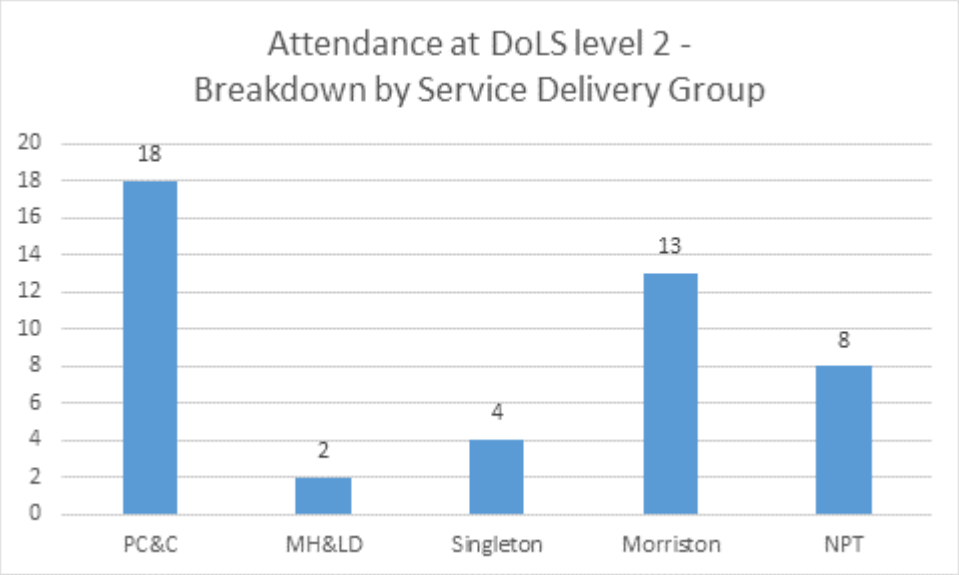
In addition to formal training, learning from Safeguarding cases, including MCA/DoLS, is disseminated widely across the Health Board. As with DoLS, MCA support has been given by the BIAS within the Service Delivery Groups.

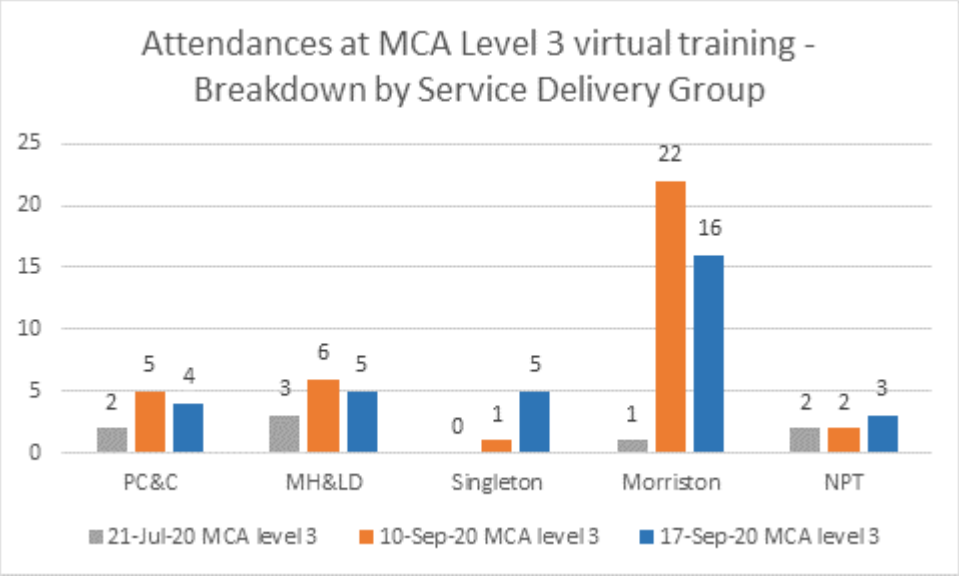
The IMCA quarterly monitoring reports are shared via Safeguarding Committee and include case scenarios.

As a response to COVID-19 all Safeguarding training was suspended in March, therefore, in Quarter 1, no MCA Level 3 training took place. In June, the Corporate Safeguarding Team began work to determine a way forward to provide Safeguarding training, including MCA Training allowing for maximum attendance whilst taking into account all relative government guidance. Social distancing measures mean that all training venues have had their capacities reduced to approximately 30% and as such training has had to be adjusted to accommodate this. The first session of virtual MCA Training was delivered by Swansea University on 21st July with a total of 8 staff attending via Microsoft Teams. Evaluations from all training delivered in July has been positive with both face to face and virtual attendees feeling included and reporting that the blended learning format was working well.

Feedback from the DoLS training has also been positive, with attendees indicating that they found the webinar format useful, and felt more able to ask questions than in a face-to-face session. Further dates for training have since been released and since re-advertising future bookings have increased and future attendances are expected to increase as a result.

The graphs below indicate training attendances during the reporting period.





INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCAs)

The Independent Mental Capacity Advocate (IMCA) service is a statutory service which came into effect in Wales on the 1st October 2007. IMCAs are independent advocates who represent people who lack capacity in order to support them in making important decisions, which must comply with the MCA 2005. An IMCA must be appointed for anyone aged 16 or over who has been deemed as lacking capacity and are unfriended; they can also be appointed for Care Reviews or Adult Protection cases.

The IMCA service that is currently contracted to the HB is provided by Mental Health Matters Wales, quarterly monitoring reports are provided to the Health Board. The below table indicates the number of new instructions for an IMCA from the HB during Quarters 1 & 2.

Q1 & 2 .BREAKDOWN OF REASONS FOR INSTRUCTION OF AN IMCA

	Serious Medical Treatment	Long term move of accommodation	Care Review	Vulnerable Adult	39a*	39d*
Q1	9	7	1	2	2	0
Q2	1	10	1	1	3	1

***** These different categories are, when a person who is deprived of their liberty, does not have a representative e.g. a friend, family member or advocate

The IMCA Service reported that during this reporting period, they continued to receive a similar number of referrals to previous quarters despite the Coronavirus pandemic**.** They have adapted to maintain contact with clients, professionals and care providers via phone and video conferencing services.

COURT OF PROTECTION (CoP)

The Court of Protection (CoP) is a key decision making component of the Mental Capacity Act and has jurisdiction over property, financial affairs and the welfare of people who lack capacity. It has the same powers, rights, privileges and authority as the High Court. It was identified in late 2019 that links between the Corporate Safeguarding Team and the Legal Team have not been sufficiently robust to enable a regular oversight and assurance regarding CoP cases.

In January 2020 a Datix Change request was submitted to the Datix User Group meeting by the Mental Health & Learning Disabilities Delivery Unit to request an addition to the Complaints Module of Datix to enable capture of the CoP cases. This change has now been made and all Delivery Units have been notified. A new code 'type' has been added to the Complaints Module- 'Court of Protection'. This allows secure storage of documents and maintenance with a central oversight of CoP cases.

These records will be available and managed by the Units with the ability to report on all cases on a Health Board wide basis.

Ongoing Identified Risks

COVID-19

There have been no adjustments to Mental Capacity Act and Deprivation of Liberty Safeguards Legislative responsibilities during COVID pandemic, any deprivation of liberty needs to be authorised. There are ongoing risks to Health Board compliance with legislation:

- Lack of availability of assessors to undertake the assessments, particularly BIA's largely relying up on the two dedicated BIA's to undertake all assessments

- Restrictions to visiting patients to carry out assessments and the requirement to reduce footfall on hospital sites to minimise spread of infection
- Limited ability to undertake remote assessments (lack of equipment and time for front line staff to support the patient with the assessment)
- There is a back log of cases awaiting assessment with 83 outstanding assessments.

In view of the above risks, the following recommendations were escalated **(Appendix 3)** and agreed:

- BIA's will only be undertaking face-to-face assessment on the acute sites in urgent cases such as Court of Protection or for cases where ward staff require support due to behavioural concerns.
- A telephone triage and support service will be available Monday to Friday 9am to 5pm.
- BIA's will work with staff in the acute settings to ensure robust care plans are in place.
- For patients with existing DoLS the review will be undertaken remotely where possible and the previous Section 12 Doctors report will be used.
- Admin support will still be available.
- BIA's will support acute staff with any complex cases and to ensure patients are not delayed in hospital for concerns related to best interest decisions.
- Resume normal service as soon as possible.

In addition:

- As part of triage BIA's have put in place 'traffic light' prioritisation for transparency and consistency.
- All guidance has been updated in line with government's updated guidance and widely circulated to relevant staff.

Breaches

There is a significant improvement in compliance, however, 46.5% of referrals breach. The actions taken include encouraging MA's to submit a Form 1a (providing a further 7 day extension). COVID-19 has had an impact on the number of breaches during the last quarter, for reasons stated above.

Mental Capacity Act

MA compliance: Evidence of inconsistent understanding and implementation of MCA/DoLS across the service areas, our observations are that compliance and application is significantly better where ward leads have an interest in MCA/DoLS and have attended training or are BIA trained. In other areas there is a clear deficit where frontline staff are not confident or are lacking the skills and knowledge in undertaking mental capacity assessments and completing best interest meetings. This is a concern particularly for the future in relation to LPS as there is likely to be greater responsibilities on MA's when LPS is implemented.

Theme: There is a common misunderstanding that a patient has to have a DoLS authorisation in order for MA's to access additional support (1:1) or access support from onsite security services. This triggers inappropriate referrals and evidences the lack of knowledge and application of the use of the MCA without the need for DoLS.

Liberty Protection Standards (LPS)

There are new legislative changes moving from Deprivation of Liberty Safeguards to Liberty Protection Safeguards, date for implementation of new scheme has been delayed due to COVID-19, the new date for implementation is April 2022. The Managing Authority is still awaiting further legislative guidance in order to determine the future DoLS team structure. In the interim MCA and DoLS will remain core business, there has been no change to SBU HB's statutory obligations during the pandemic.

LPS scheme arrangements will cover hospitals, independent hospitals, care homes, supported living, shared lives and private and domestic settings. The LPS can also provide authorisation of day centre and transport arrangements. Authorisations can also be for multiple settings built into the person's care plan.

LPS will apply to people aged 16 or over in line with the MCA 2005 (16-17 year olds).

A Responsible Body will replace the Supervisory body, as the agency responsible for authorising the LPS arrangements that amount to a deprivation of liberty. There is likely be an increase in the volumes of assessment requests for SBUHB, as a consequence of care and treatment arrangements that are carried out mainly through the provision of NHS Continuing Health Care in nursing homes, as the responsible body will be the relevant Health Board in Wales.

The LPS will have a pre-authorisation review which can be completed by either an Approved Mental Capacity Professional (AMCP), or 'some other health or care professional', Welsh Government will set out in the regulations relating to who can undertake a pre authorisation review. As this is not normally expected to be an AMCP, unless for example the person is objecting to their care and treatment, or family, advocate IMCA raises an objection to the current or proposed care and treatment arrangements**.**

As of 16th July 2020, the UK Government announced a new date for LPS with full implementation aimed for April 2022. A link to the full ministerial announcement can be found here: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2020-07-16/HCWS377/

4. FINANCIAL IMPLICATIONS

A review of SBUHB's service model compared to other Health Boards has shown a difference in how services are funded. Considering the similar level of referrals the comparison has highlighted that the level of funding and resource available for the SBUHB Supervisory Body is significantly lower than that of other HB's (Appendix 4). This should remain under review in light of the

implementation of LPS. In order for the Health Board to meet the new LPS legislative requirements a workforce review will be undertaken. In view of the preperations required and lead in time to LPS a new 8a lead role will be explored to ensure the Health Board can meet the new LPS and MCA legislative requirements.

5. RECOMMENDATIONS

Members are requested to note:

1. Performance data for Quarter 1 April to 30 June 2020 and Quarter 2 July to 30 Sept 2020

2. Further LPS guidance has been delayed due to the COVID-19 pandemic. The new implementation date, has been confirmed as April 2022.

3. The COVID pressures and impact on management of DoLS applications

4. The impact of COVID on management capacity to develop a business case for a new DoLS service to fully meet Health Board requirements.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☒
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Report highlights the importance of safe and timely assessment		
Financial Implications		
Report identifies the current financial challenges and lack of funding for Supervisory Body Function.		

Legal Implications (including equality and diversity assessment)	
Report reference the legal framework which is current and the future LPS implementation	
Staffing Implications	
Report outlines the current staffing capacity issues and identifies the potential for future staffing model to become compliant.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
Report makes reference to future legislation.	
Report History	Presented to MHA&MCA Compliance Committee in August
Appendices	**Appendix 1** provides performance information Q1 **Appendix 2** provides performance information Q2 **Appendix 3** SBAR Current DoLS Service **Appendix 4** SBAR DoLS Service Model Going Forward  Appendix 1 - DoLS Referral Data Qtr 1.c  Appendix 2 - DoLS Referral Data Qtr 2.c  Appendix 3 SBAR Current DoLS Servic  Appendix 4 SBAR DoLS Service Model.