Deprivation of Liberty Safeguards

Annual Monitoring Report for Health and Social Care 2017-18

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Deprivation of Liberty Safeguards

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Contents

Key Findings

- A total of 14,743 new DoLS applications were received by Health Boards and Local Authorities in 2017/18; an increase of 8 percent from the previous year.
- The majority of individuals who were subject to a DoLS in 2017/18 were female and over the age of 65.
- There were approximately 590 DoLS applications for every 100,000 people in Wales in 2017/18.
- 47 percent of all applications were for a Standard authorisation, 39 percent for an Urgent and 14 percent for a Further authorisation
- 31 percent of all DoLS applications were authorised, 22 percent were withdrawn and 6 percent were refused. The remainder were still in progress at the end of the year.
- Roughly half (48 percent) of Standard applications, and two thirds (66 percent) of Urgent applications, did not receive a decision within the timescale required by statutory timescales; the proportion being assessed within the timescales has improved since last year.
- For all applications, the average length of time between receiving an application form and a decision being made was 83 days
- 113 authorisations underwent a review, and 72 applications were challenged in the Court of Protection, in 2017/18

Introduction

This is the annual monitoring report of Care Inspectorate Wales and Healthcare Inspectorate Wales on the implementation of Deprivation of Liberty Safeguards in Wales, on behalf of Welsh Ministers.

The report examines the key findings for the year 2017/18, providing an analysis of the information and a description of trends, concerns and achievements. It is designed to contribute to the improvement in outcomes for people in need of support from the Deprivation of Liberty Safeguards.

Care Inspectorate Wales and Healthcare Inspectorate Wales aim to review their approach to monitoring DoLS to focus more on the experience of and outcomes for people whose liberty has been deprived. The aim is to do this alongside the amendments to legislation, which will usher in the Liberty Protection Safeguards. The revised legislation will result in changes in practice for Supervisory Bodies and Managing Authorities and as a consequence, changes to how we monitor implementation. The delays in the implementation of this legislation have meant the qualitative analysis is limited in this report.

Deprivation of Liberty Safeguards (DoLS)

People who are not able to make some or all of their own decisions due to a lack of capacity are protected and empowered by the Mental Capacity Act 2005[1] (MCA). The purpose of this Act was to establish mental capacity and the Court of Protection. The MCA sets out who can make decisions for a person who lacks capacity, when and how. It ensures that decisions are made in a person's best interests and the person is involved in the decision as much as possible. The safeguards provide for access to advocates and the right to legally challenge any deprivation of liberty.

The DoLS were introduced as an amendment to the MCA and came into force in April 2009. The DoLS are additional safeguards to protect the rights of people who are deprived of their liberty to protect their health and safety.

A Supreme Court ruling in March 2014[2] clarified the definition and widened the scope of when someone is being deprived of their liberty. This change introduced new tests and checks around:

a) when a person is under continuous or complete supervision and control,
b) and is not free to leave,
c) and the person lacks capacity to consent to these arrangements.

The Supreme Court ruling has resulted in a very large increase in the number of applications for DoLS authorisations. This increase has created a backlog for Health Boards and Local Authorities.

The House of Lords published a scrutiny report[3] (2014) of the Mental Capacity Act 2005. The report concluded that DoLS were "not fit for purpose" and recommended they be replaced. The Law Commission, sponsored by the UK Government produced a report in March 2017[4], setting out new 'Liberty Protection Safeguards' and recommending DoLS be repealed. A full UK Government response was produced in March 2018, which agreed that the current DoLS system should be replaced as a matter of urgency and broadly agrees with the 'Liberty Protection Safeguards' model.

The UK Government introduced a Mental Capacity (Amendment) Bill [HL] in July 2018 broadly based on the Law Commission's proposals[5]. The passage of the Bill the Bill through Parliament is ongoing and significant amendments have been made since its introduction. The current DoLS procedures and need to monitor the operation of the scheme will continue until any changes to the law receive Royal

[1] See https://www.legislation.gov.uk/ukpga/2005/9/contents
[2] See https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf
[3] See https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm
[4] See https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/lc372_mental_capacity.pdf
[5] https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html

Assent and are implemented. The UK Government will also be updating the Codes of Practice to both the Mental Capacity Act and DoLS to reflect changes to the law.

The Welsh Government produced guidance in 2015 on the forms that are to be used when applying for a deprivation of liberty[6].

DoLS are used only in hospitals and care homes. These are called '**managing authorities**'. The bodies that authorise DoLS applications are called '**supervisory bodies**'.

Hospitals apply to their local/corresponding Health Board (HB) to authorise any DoLS applications made,

Care homes apply to their Local Authority (LA) for such authorisation. In Wales, the authorising Local Authority is the Local Authority in which the individual is ordinarily resident before placement in the care home.

There are three main types of applications that can be made for an individual: **Standard**, Standard following urgent (or just **Urgent**) and **Further**. A Standard application is used when the requirement for a DoLS application can be predicted and there is sufficient time to make an application before it is required. For example, if an individual who would require some form of deprivation of liberty is moving into a care home, the home can make an application in advance of the move. The application can be made **28 days** in advance of requiring the authorisation to be in place, therefore, the assessments relating to Standard applications should be completed by the supervisory body within this time.

Where a deprivation of liberty is required to commence immediately, or before a Standard authorisation can be obtained, managing authorities use an Urgent authorisation. In this case, the managing authority can authorise themselves for a deprivation of liberty for **up to seven days**[7]. All Urgent authorisations also come with an application for a Standard authorisation, which should have been processed within the seven-day period in which the managing authority is 'self-authorised'.

Urgent applications are only to be used when the requirement for deprivation of liberty cannot be predicted. For example, when an individual is admitted into hospital or care home due to an unforeseen occurrence.

In addition to the Standard and Urgent types, any application for an individual who already has a DoLS authorisation in place (i.e. to renew/refresh), a Further application is made to the supervisory body. These act as a normal Standard

[6] https://gov.wales/docs/dhss/publications/151029guidanceen.pdf
[7] An extension for an additional seven days can be sought in some circumstances.

application, but are for a continuation of the current authorisation. A review of conditions and eligibility is still undertaken.

The Code of Practice[8] states any authorisation, regardless of type, should be for the shortest possible duration and for only as long as the relevant person will meet the required criteria. Roughly half of all authorisations made by Local Authorities are for the full year.

When deciding whether an application should be authorised, there are **six assessments** that must be made (see Glossary). These are:

- Age
- Best Interests
- Mental Capacity
- Eligibility
- Mental Health
- No Refusals

DoLS can only be authorised where detention under the Mental Health Act[9] (1983) is not appropriate. DoLS authorisations are only valid for **up to a year**, but managing authorities should only apply for the shortest time they expect the authorisation will be required.

In addition to not meeting the requirements of these assessments, applications may be withdrawn, cancelled, or the person has moved care home or been discharged from the hospital, making the application unnecessary. The main reasons for applications were withdrawn were because the person:

- Had moved home, which means a new application must be made if required.
- Had been discharged from hospital.
- Had died before a decision has been made.
- Had been detained under Mental Health Act.

Finally, and crucially any authorisation can be reviewed at the request of the individual, their representative, the managing authority or the supervisory body. This usually occurs when the individual's situation changes or if it is felt the criteria for authorising the application are no longer met. Any authorisation for a deprivation of liberty can also be challenged, usually by the individual's representative, in the Court of Protection[10].

Data was collected from Local Authorities and Health Boards in May 2018 in regards to the DoLS applications they received in the 2017/18 financial year. The data

[8] See http://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
[9] See http://www.legislation.gov.uk/ukpga/1983/20/contents
[10] See https://www.gov.uk/courts-tribunals/court-of-protection

provides anonymous details of the individual a deprivation was applied for and their application/authorisation.

This data collection underwent a change for the 2017/18 data to now include a wider range of dates in regards to when the forms were received, allocated to a relevant assessor, decision made and proposed end date. This allows for a more accurate understanding of the timescales involved in processing the forms. There is also now a greater emphasis on capturing information about ongoing authorisations and Further applications.

Due to the forthcoming changes in DoLS legislation, it is likely the data collection will also need to change. However this will occur in line with the wider changes to the DoLS processes. It is important to continue the current collection method, so that were is an accurate baseline as parliament considers our moving towards new liberty protection safeguards. The impact this will have on the data will be clearly laid out in future reports.

In view of the recognised ongoing challenges of operating the DoLS scheme across England and Wales, the Welsh Government have allocated an additional and recurrent £329,000 to all Local Authorities and Health Boards for a 3 year period from April 2018 until any changes in the law are known and implemented.

Results

Demographic Profiles

The demographics of individuals with a DoLS application are generally reflective of the populations served by each of the supervisory bodies. According to the latest Census, the majority of older people (over the age of 65) living in care homes are female (74 percent female) and/or over the age of 85 (59 percent aged 85 or older)[11]. Therefore, the main group of individuals with a DoLS authorisation in care homes are elderly, female individuals, with nearly 4,000 females over the age of 85 having an application for a DoLS in 2017/18, see Figure 1.

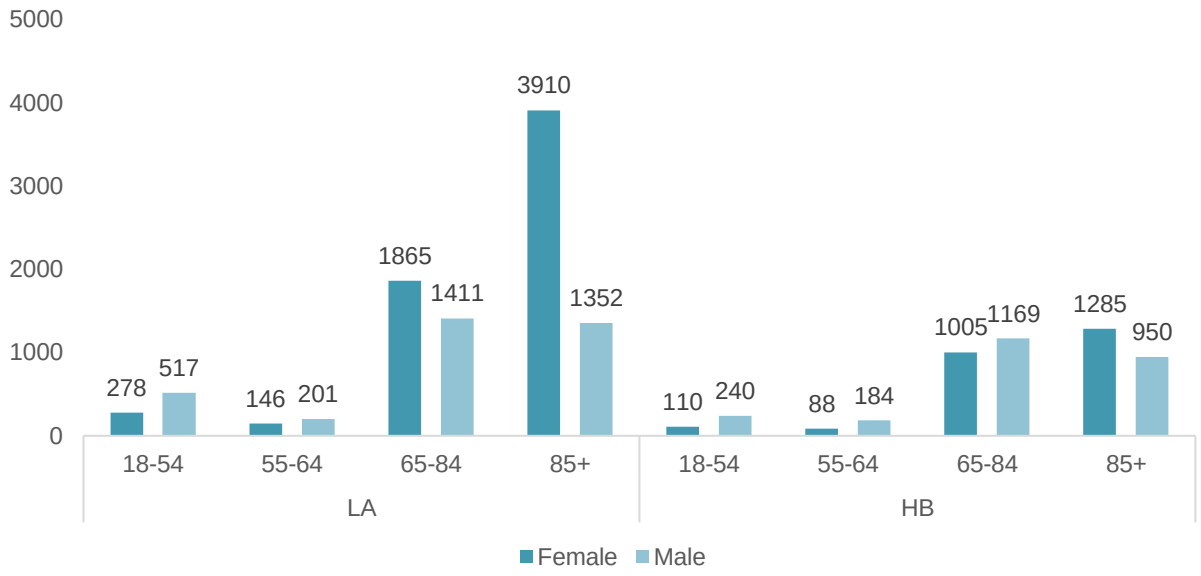
DoLS applications are almost exclusively applied for older people, with 88 percent of people subject to an application in 2017/18 were age 65 or older, and 51 percent were over the age of 85.

Also, 59 percent of all applications were for a female, which rises to 62 percent for only those aged 65 and over, and 69 percent for only those aged 85 or over, in line with the population differences in this age group. However, this gender difference is

[11] See https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/changesintheolderresidentcarehomepopulationbetween2001and2011/2014-08-01

greater than found in the general population of Wales, where 54 percent of those aged 65 or over, and 64 percent of those aged 85 or over, are female[12].

Figure 1. The breakdown of age by gender of the individual in Local Authorities and Health Boards for all applications in 2017/2018



Number of applications

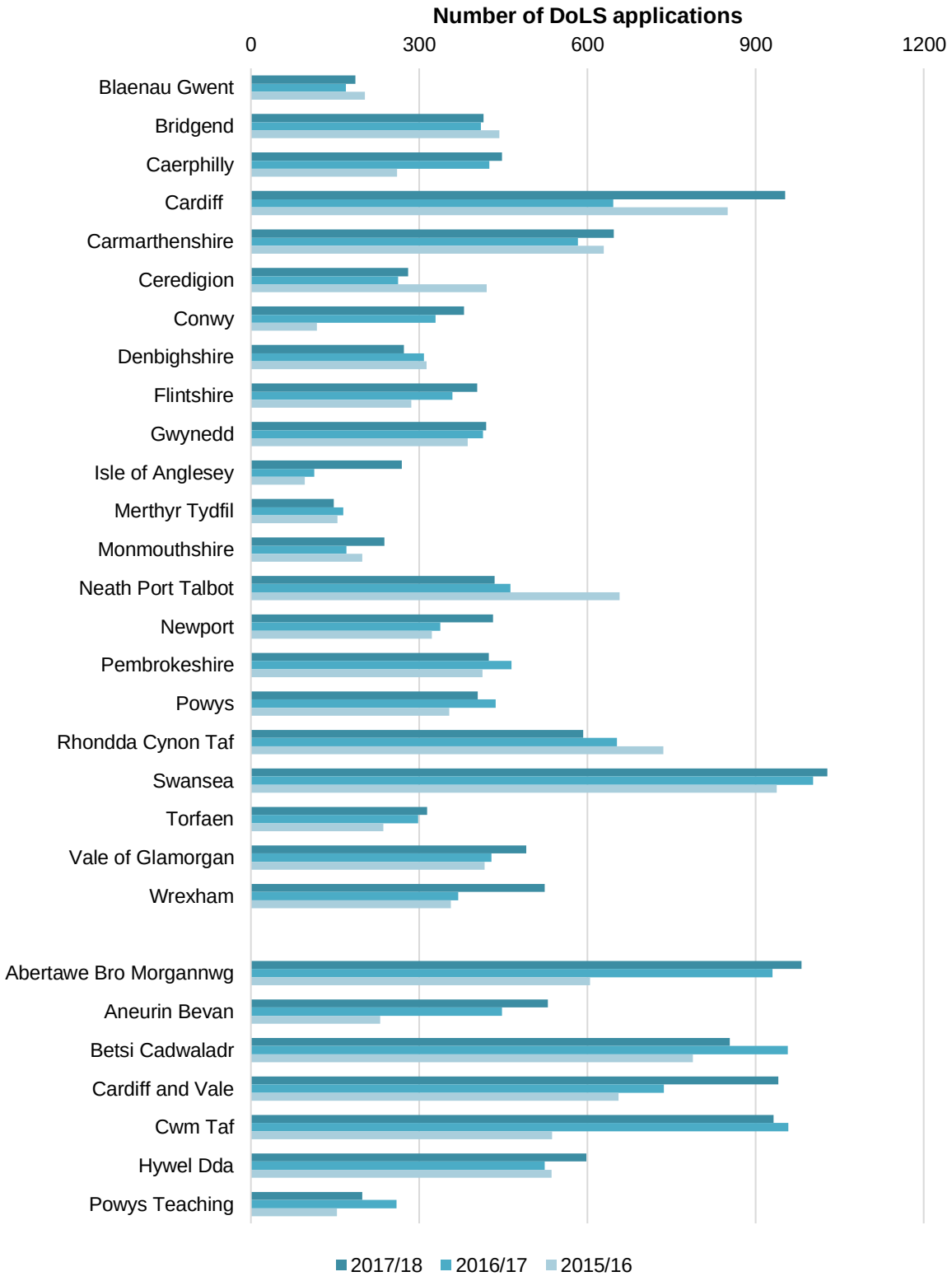
A total of 14,743 new, and further DoLS applications were received by Health Boards and Local Authorities in 2017/18 (5,036 for Health Boards and 9,707 for Local Authorities). This means the number of applications has increased by 8 percent, from 13,627 in the previous year (see Figure 2), despite only a 0.4 percent increase in the Welsh population[13].

Local Authorities continue to receive the majority of applications, with an increase of 10 percent from last year, up from 8,811 in 2016/17 to 9,707 in 2017/18. This means they received 66 percent of all applications. Health Boards had a 5 percent increase in applications from 4,816 in 2016-17 to 5,036 in 2017-18.

There is considerable variation in terms of their overall levels, and their change over time. This can be caused by a large number of factors, such as changes in local processes or the opening and closing of Managing Authorities. Figure 2 shows the details of these changes.

[12] See https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/nationallevelpopulationestimates-by-year-gender-ukcountry
[13] See https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates

Figure 2. The number of DoLS applications received by each Local Authority and Health Board from 2015 to 2018



In 2017 the estimated population of Wales, was 3.1 million, of which 2.5 million are over the age of 18[14]. This means that on average there were 590 applications for every 100,000 adults in Wales[15] (see Table 1).

Similar to the total numbers, the number of applications relative to the population has considerable differences between Local Authorities and Health Boards. This will again depend on local processes, local demographics and also the number of Managing Authorities in that area.

Table 1. The total adult population and number of DoLS applications received by each Local Authority and Health Board and the number of applications per 100,000 adult population in 2017/2018

	Total 18+ Population	Number of DoLS applications	DoLS applications per 100,000
Local Authorities			
Blaenau Gwent	56,054	186	332
Bridgend	115,071	415	361
Caerphilly	142,461	448	314
Cardiff	288,601	953	330
Carmarthenshire	149,356	647	433
Ceredigion	60,755	280	461
Conwy	95,364	380	398
Denbighshire	75,794	273	360
Flintshire	123,127	404	328
Gwynedd	100,332	420	419
Isle of Anglesey	56,365	269	477
Merthyr Tydfil	47,217	148	313
Monmouthshire	76,004	238	313
Neath Port Talbot	114,199	435	381
Newport	117,014	432	369
Pembrokeshire	100,513	424	422
Powys	108,273	405	374
Rhondda Cynon Taf	189,215	593	313
Swansea	198,208	1028	519
Torfaen	73,176	314	429
Vale of Glamorgan	103,446	491	475
Wrexham	106,331	524	493
Local Authority Average	**113,494**	**441**	**389**
Health Boards			
Abertawe Bro Morgannwg	427,478	982	230
Aneurin Bevan	464,709	530	114
Betsi Cadwaladr	557,313	854	153

[14] See https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/nationallevelpopulationestimates-by-year-gender-ukcountry
[15] https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates

Cardiff and Vale	392,047	941	240
Cwm Taf	236,432	932	394
Hywel Dda	310,624	598	193
Powys Teaching	108,273	199	184
Health Board Average	**356,697**	**719**	**201**
Total	**2,496,876**	**14,743**	**590**

Types of applications

The legislation makes provision for care homes and hospitals to make Standard, Urgent or Further applications. A Standard application is to be used when there is no requirement for the authorisation to already to be in place (i.e. an application for a requirement in the future). An Urgent application is intended for use when the requirement for a deprivation is required immediately. A Further is a review/refresh of an existing authorisation.

On average, 47 percent of all applications were for a Standard authorisation, 39 percent for a Standard following Urgent and 14 percent for a Further authorisation. As many people are admitted to hospital unexpectedly, Health Boards were more likely to receive Urgent applications than Local Authorities; 54 percent of applications to HBs are for Urgent authorisations.

There is a high level of inconsistency between Local Authorities and Health Boards in the proportion of their applications that are Urgent or Standard. This is largely due to local processes and instructions given to Managing Authorities by the Supervisory Bodies. For example, some Supervisory Bodies will ask that all applications be sent in as Standard, and that they will reassessed and prioritise once received. While this may be common across multiple areas, some may record the applications as Standard, and some may record as the newly prioritised category.

These percentages vary for each age group and supervisory body, see Table 2. The percentage of applications that are for a Further authorisation is substantially higher for those under the age of 65.

People spend more time in their residential setting, rather than in a hospital, which means the percentage of those receiving a request for a Further application is higher for residents of care homes, with roughly 36 percent in Local Authorities and 15 percent in Health Boards.

Table 2. The percentage of different application types for different age groups in local authorities and Health Boards in 2017/2018

	18-54	55-64	65-84	85+
Local Authorities				

Standard	47.5%	41.2%	57.3%	63.5%
Urgent	16.3%	22.5%	25.5%	21.7%
Further	36.2%	36.3%	17.3%	14.8%
		Health Boards		
Standard	15.5%	20.9%	23.9%	26.2%
Urgent	69.0%	64.1%	71.8%	69.8%
Further	15.5%	15.0%	4.3%	4.0%

Existing authorisations

As of 1st April 2018, 4,672 DoLS authorisations were in place across Wales, of which 3,245 (69 percent) were for individuals living in Care Homes. There were also an additional 4,930 applications still in progress, of which 4,459 (90 percent) were being processed by LAs. This means roughly 0.2 percent of the whole population of Wales has a DoLS authorisation in place, and a further 0.2 percent have an application for one.

In 2016/17, 4,558 applications were processed (i.e. not withdrawn before being allocated to an assessor). In 2017/18, 5,118 applications were processed, suggesting that supervisory bodies are able to process applications more efficiently or quickly, compared to 2016/17. This is supported by the fact that at the end of 2016/17 there were 4,645 applications still in progress; the same amount as 2017/18 despite the higher volume received in 2017/18.

New authorisations

One of the changes to this year's data collection is to ask specifically about Further applications. Previous collections grouped Further with Standard, and so this detail was lost. This change allows for a more accurate understanding of long term authorisations that get renewed, but also that the number of Further applications cannot be accurately compared against previous years.

Of all the DoLS applications received in 2017/18 (14,743), 31 percent (4,604) were authorised, 22 percent were withdrawn[16] (3,211) and 6 percent were refused (834). Therefore, if only those applications that were processed are considered (i.e. not still in progress or withdrawn), the authorisation rate rises to 84 percent. This means relatively few applications received by supervisory bodies were refused. It is far more likely that the application is no longer needed before it is assessed, rather than the recommendation being to refuse the application (see Table 3).

[16] The main reasons given for applications being withdrawn are that the individual has either been discharged from hospital or moved care home. Future data collections will be requesting supervisory bodies to give the reason for withdrawal.

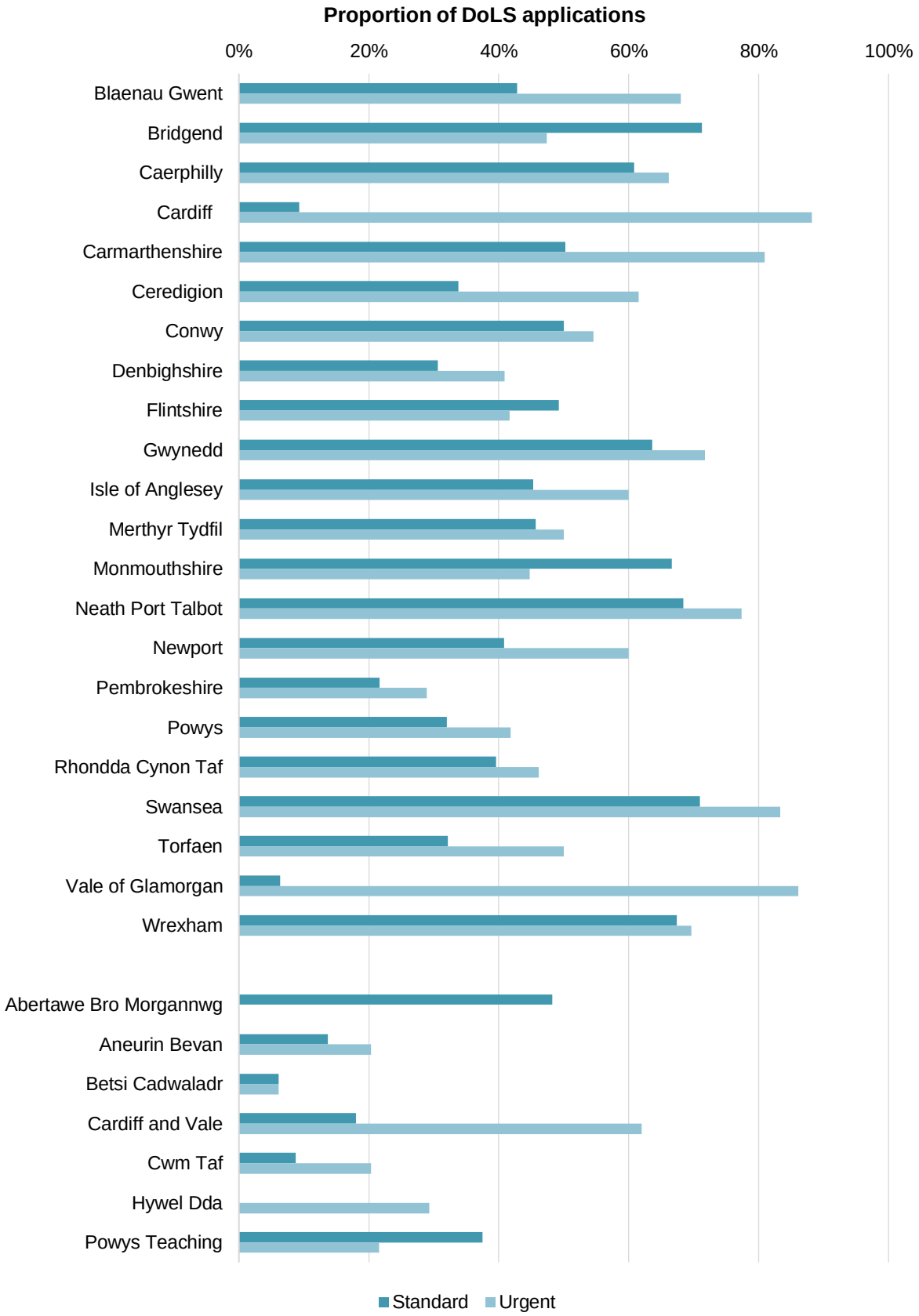
Table 3. The proportion of applications that weren't authorised by Local Authorities and Health Boards by reason for refusal in 2017/2018[17]

	Age	Best interest	Eligibility	Mental Capacity	Mental Health	No Refusals	Not a deprivation	Withdrawn
LA	0.0%	0.1%	2.1%	5.6%	3.3%	0.0%	2.1%	86.8%
HB	0.0%	1.8%	2.9%	11.7%	0.6%	0.0%	2.1%	80.9%
Total	**0.0%**	**0.8%**	**2.4%**	**8.0%**	**2.2%**	**0.0%**	**2.1%**	**84.5%**

Local Authorities authorised 3,194 applications in 2017/18, which represents 69 percent of all authorised applications in Wales. If applications still in progress, were withdrawn or were inappropriate, Further/ Re-assessments were the least likely type of application to be refused, with less than five percent (50 out of 1,174) not being authorised; Standard and Urgent were authorised at a rate of 84 percent (336 out of 1,983) and 86 percent (479 out of 2,316), respectively (see Figure 3).

[17] Details of the different assessments can be found in the Glossary

Figure 3. The proportion of applications that were authorised by each Local Authority and Health Board in 2017/2018



Health Boards authorised 1,410 applications, but were more likely to refuse an application than Local Authorities. While Further/Re-assessments were still likely to be authorised, only 77 percent (204 applications) and 71 percent (1,052 applications) of Standard and Urgent applications respectively were authorised.

Authorisation rates were slightly higher for younger individuals. An average of 62 percent of authorised applications concerned individuals aged 18-54 being, compared to 43 percent in those aged 85 or over (see Table 4).

Table 4. The authorisations rates for different demographic groups in local authorities and Health Boards in 2017/2018

	18-54	55-64	65-84	85+
		Local Authorities		
Male	80%	78%	59%	50%
Female	71%	79%	64%	59%
		Health Boards		
Male	44%	40%	31%	28%
Female	39%	42%	32%	27%

Application Timescales

Whilst guidance[18] says Standard applications should have been received and a decision made within the 28 days before it is required, 48 percent (706 out of 1,482 applications that had a decision) took more than 28 days to process. Similarly, 66 percent (1,344 out of 2,049 applications that had a decision) of Urgent applications took more than 7 days. As seen in Table 5, 51 percent of Standard and 61 percent of Urgent applications to Local Authorities took longer than stated in the guidance; 27 percent of Standard and 69 percent of Urgent applications to Health Boards took more than 28 or 7 days, respectively.

Table 5. The length of time taken to process Standard and Urgent applications for Local Authorities and Health Boards in 2017/18

	Same day	1-7 days	8-14 days	15-28 days	Over 28 days
			Standard		
LA	2.14%	6.49%	6.10%	34.05%	51.23%
HB	6.36%	21.82%	16.82%	28.18%	26.82%
			Urgent		
LA	6.20%	32.71%	20.45%	17.60%	23.05%
HB	7.73%	23.75%	24.72%	26.97%	16.83%

[18] https://gov.wales/docs/dhss/publications/151029guidanceen.pdf

Despite the number of applications taking longer than stated in the guidance, the proportion being assessed within the timescales has improved since last year. In 2016/17, only 23 percent of Standard and 14 percent of Urgent applications were within the required timescales. However, this rose to 52 percent for Standard and 39 percent of Urgent in 2017/18.

Once a form is received, it is logged and prioritised before being allocated to the relevant assessors for their recommendation about whether or not to authorise. In 2017/18, the data collection was expanded to request the dates of applications being received and allocated, in addition to the dates the decision was made to authorise or refuse and proposed end date. This allows for the calculation of the average number of days taken to process an application form.

Of the 5,484 applications (3,644 to Local Authorities and 1,840 to Health Boards) that had a decision made, the average length of time between receiving a form and a decision being made was 83 days (134 days for Local Authorities and 27 days for Health Boards). Standard applications take on average, over twice as long to have a decision made as Urgent applications, see Table 6.

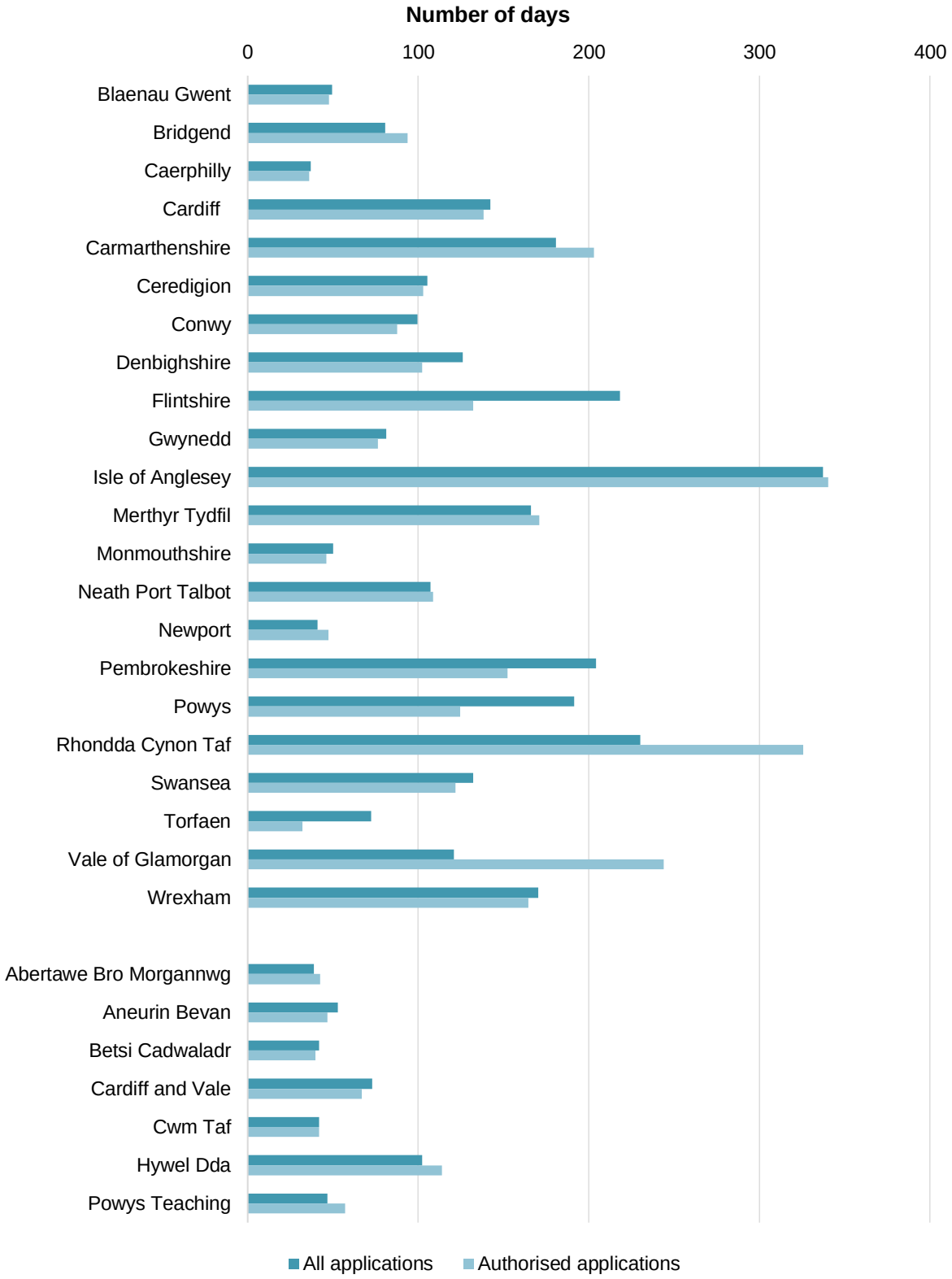
Therefore, Urgent applications are processed faster than Standard, but both are taking longer than is recommended in the statutory timescales. However, the average number of days taken for a decision does not vary much for those applications that were refused or authorised (see Figure 4).

Table 6. The average number of days taken to process Standard or Urgent applications for Local Authorities and Health Boards in 2017/18

	Days between date on form and being logged	Days between being logged and allocated	Days between being allocated and a decision	Total
		Standard		
LA	28.0	89.0	34.6	151.6
HB	1.9	8.2	19.6	29.7
Total	23.6	52.2	30.5	106.3
		Urgent		
LA	6.4	67.6	13.3	87.2
HB	2.9	16.3	5.9	25.0
Total	4.5	32.8	8.9	46.2

The main period of delay occurs between a form being logged and being allocated to an assessor. In Local Authorities, once a form has been logged, it takes on average 82 days for it to be allocated, then a further 29 days for a recommendation to be made. Health Boards typically take around 13 days to allocate and 12 days for a recommendation.

Figure 4. The average number of days between an application being received and a decision being made (excluding withdrawn applications) in each Local Authority and Health Board in 2017/2018



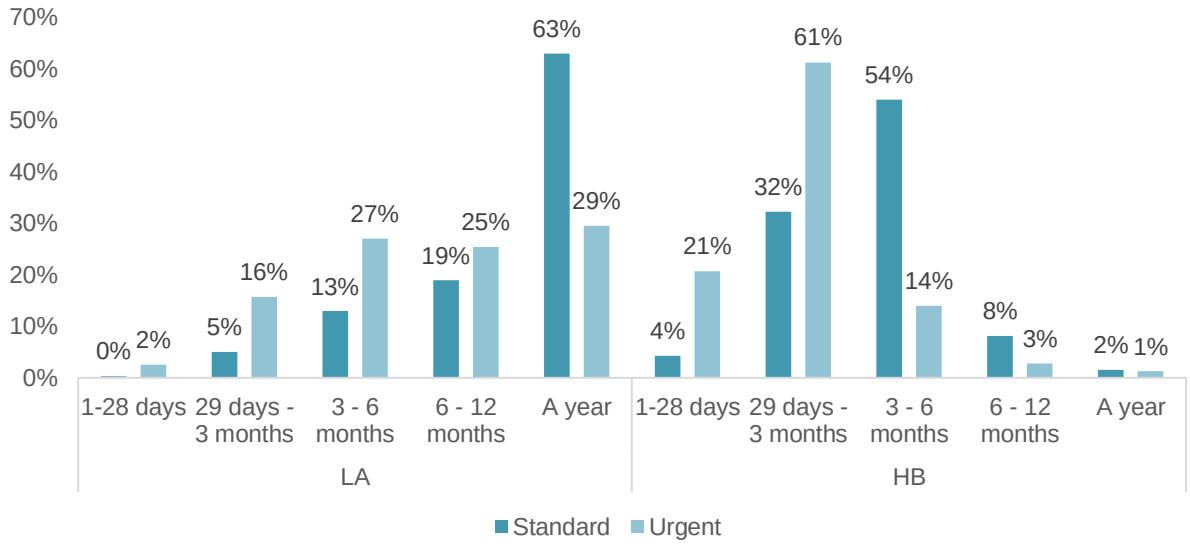
Authorisation durations

The Code of Practice[19] states any authorisation should be for the shortest possible duration and for only as long as the relevant person will meet the required criteria. Roughly of all authorisations made by Local Authorities are for the full year. The majority of authorisations made by Health Boards are for six months or less, see Figure 5.

All authorisations require a proposed end date, in which the authorisation will come to an end. Authorisations can end before that date for several reasons, such as the resident of a care home moving to a different home, or a patient in a hospital being discharged early.

The most common situation where a DoLS ended before the proposed end date was when a patient was discharged from hospital. Forty-six percent of all authorisations that end early was due to discharge. The next most common was the death of the individual, which accounted for 17 percent of the authorisations that ended early. There are also small number of authorisations that ended because the authorisation was no longer deemed valid, either by the Court of Protection or because the individual no longer met the requirements.

Figure 5. The proposed duration of applications that were authorised by each Local Authority and Health Board in 2017/2018



Reviews, Representatives, Independent Mental Capacity Advocates (IMCA) and Court of Protection

Any authorised Deprivation of Liberty can undergo a review. However, only 113 authorisations underwent a review in 2017/18, 2.3 percent of all authorised

[19] See http://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

applications[20]. This is approximately half of the number reviewed in 2016/17, despite the increase in the number of applications and existing authorisations.

All applications for a DoLS should have a named representative for the individual, who can promote their best interests and make sure their needs are considered. The most common person to be named as a representative is a family member or relative, with 58 percent in Local Authorities and 55 percent in Health Boards.

The next most common person to be named as a representative is some form of paid, independent representative, with 29 percent of representatives in Local Authorities being paid, and 44 percent in Health Boards. The remaining representatives are typically unpaid carers, who are not family, or friends.

One example of a paid representative is an IMCA. IMCAs are a safeguard for people who lack capacity to make some important decisions. The IMCA role is to support and represent the person in the decision-making process and make sure that the Mental Capacity Act 2005 is being followed.

There are three roles for IMCAs in cases of deprivation of liberty (39A, 39C and 39D):

- 39A appointed when the individual has no one to consult;
- 39C appointed in a case where the individual's representative is temporarily or suddenly no longer able to represent them; and
- 39D appointed to support the individual's representative, if that representative is unpaid (e.g. family member), and it is believed by the supervisory body is in need of support.

A total of 72 applications were challenged in the Court of Protection in 2017/18, three more than in 2016/17 and 33 more than 2015/16. The increase in the number of challenges over this period is greater than the increase in the number of authorisations.

Data Quality

The data in this report is used to monitor the use of the deprivation of liberty safeguards throughout Wales. It is submitted by Local Authorities and Health Boards to CIW but it is not verified by either CIW or HIW.

The definition of what constitutes a deprivation of liberty was changed in 2014, and so data collected in the 2013/14 financial year is not directly comparable to that collected for the 2014/15, 2015/16 and 2016/17 financial years. More information about the changes introduced can be found here:

[20] 14 of these were subject of multiple reviews.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf

There may be a small number of cases where applications are inappropriately labelled as either standard or urgent and there may be a margin of error in the results.

Feedback on this report

We are keen to hear from the users of our statistics. If you have any comments or queries regarding this publication or its related products, they would very be welcome. Please email the analytical team at: CIW.Analysts@gov.wales or HIW.PIM@gov.wales.

Glossary: Key terms used in the DoLS Monitoring Report

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments must be positive for an authorisation to be granted.
• **Age**	An assessment of whether the relevant person has reached age 18.
• **Best interests assessment**	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests Assessor.
• **Eligibility assessment**	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
• **Mental capacity assessment**	An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.
• **Mental health assessment**	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.

• **No refusals assessment**	An assessment of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or done appointed under a Lasting Power of Attorney.
Best Interest Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
CIW	Care Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor.

Consent	Agreeing to a course of action-specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.
Court of Protection	The specialist court for all issues relating to people who lack mental capacity to make specific decisions. It is the ultimate decision maker with the same rights, privileges, powers and authority as the High Court. It can establish case law which gives examples of how the law should be put into practice.
Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards	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

Gwent consortium	The Gwent consortium is the Deprivation of Liberty Safeguards Team commissioned by the following Organisations who, under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (2009) are known as 'Supervisory Bodies' in relation to their functions under the Act: • Aneurin Bevan University Health Board • Blaenau Gwent County Borough Council • Caerphilly County Borough Council • Monmouthshire County Borough Council • Newport City Council • Torfaen County Borough Council
HIW	Healthcare Inspectorate Wales (HIW) regulates and inspects NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations on order to highlight areas requiring improvement. .
Local Health Board	Local Health Boards fulfil the supervisory body function for health care services and work alongside partner Local Authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being. They separately manage NHS hospitals and in-patient beds, when they are managing authorities.

Independent Hospital	As defined by the Care Standards Act 2000 - a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.
Local Authority/Council	The local council responsible for commissioning social care services in any particular area of the country. Senior managers in social services fulfil the supervisory body function for social care services. Care homes run by the Council will have designated managing authorities.
Managing authority	The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the Best Interests Assessor, and it may end sooner with the agreement of the supervisory body.

Mental Capacity Act 2005	The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. The five key principles in the Act are: 1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise. 2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions. 3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision. 4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests. 5. Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.
Mental Capacity Act Code of Practice	The Code of Practice supports the MCA and provides guidance to all those who care for and/or make decisions on behalf of adults who lack capacity. The Code includes case studies and clearly explains in more detail the key features of the MCA
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for mental health treatment, supervised community treatment and guardianship.

Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.
Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Section 12 Doctors	Doctors approved under Section 12(2) of the Mental Heath Act 1983
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.

Supervisory body	A Local Authority social services or a local Health Board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
Supreme Court	The Supreme Court is the final court of appeal in the UK for civil cases, and for criminal cases from England, Wales and Northern Ireland. It hears cases of the greatest public or constitutional importance affecting the whole population
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a supervisory body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.