The Deprivation of Liberty Safeguards

A Best Interest Assessor Time Study

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Foreword

This important new piece of research should be of great interest to all those affected by the Deprivation of Liberty Safeguards. The Supreme Court's decisions in the Cheshire West and MIG and MEG cases have caused a major upheaval in the practical operation of these safeguards.

The requests for DoLS authorisations in England and Wales have increased more than tenfold in the last two years, putting local authorities under enormous pressure at a time of financial cutbacks. As well as addressing questions such as how to set priorities in this area, authorities and professionals have to consider how much time to allocate to each assessment. Clearly this will vary according to the complexity of individual cases, but how should benchmarks be sent?

Emma Goodall and Paul Wilkins have made an essential contribution to the debate with this large study which focuses on the work of the Best Interests Assessor and the time taken to complete their assessments. The information that they have gathered and analysed is fascinating and addresses a range of issues which go beyond just the question of time allocation.

The study concludes with some critical feedback from BIAs themselves on how they see the system working at present. This will be essential reading for anyone trying to plan services, as well as for those currently looking at how the system could be reformed to offer a realistic way of providing essential safeguards to some of the most vulnerable members of the community. I highly commend this study to you.

Rob Brown
(Social worker and Visiting Fellow at Bournemouth University)
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List of Terms and Abbreviations

AMHP	The 2007 Act introduced the 'Approved Mental Health Professional' ("AMHP") known previously as Approved Social Worker ("ASW")
BIA	Best Interests Assessor ("BIA") responsible for undertaking several qualifying assessments in the authorisation of the Deprivation of Liberty Safeguards
DoLS	Deprivation of Liberty Safeguards ("DoLS") a legal mechanism governed by Schedule A1 of 2005 MCA
Managing Authority	Managing Authority ("MA") are the care homes and Hospitals (Registered) who are responsible for identifying a deprivation of liberty and making an application to the Supervisory Body for authorisation under the Deprivation of Liberty Safeguards
MCA	Mental Capacity Act 2005 ("MCA") aims to empower and protect people who may not be able to make some decisions for them.
Schedule A1	Found in the Mental Capacity Act 2005 and governing the statutory Deprivation of Liberty Safeguards procedures
Supervisory Body	Supervisory Body is a role that falls to Local Authorities who are responsible for the administration and authorisation the Deprivation of Liberty Safeguards ("DoLS")

Acknowledgements

We would like to extend our warmest thanks all the BIAs who took the time to tell us about their experiences. Our thanks go also to Rob Brown and the DoLS team in Cornwall for your inspiration and support. We would also like to acknowledge the DoLS Leads Networks and the avid health and social care correspondents, bloggers and 'tweeters' who helped us to circulate the survey nationally. Your individual contributions have been invaluable, thank you.

Section one

The Deprivation of Liberty Safeguards: Best Interest Assessor Time Study

Introduction

The Supreme Court's decision in the conjoined case of *P v Cheshire West and Chester Council and another (Respondents); P and Q v Surrey County Council* [2014] UKSC 19[1], known more commonly as 'Cheshire West', has brought a momentous change to practice for Best Interests Assessors[2] ("BIA"), whose role is central in assessment for the Deprivation of Liberty Safeguards ("DoLS")[3]. BIAs are tasked with undertaking several of the qualifying assessments and in doing so they must obtain, evaluate and analyse complex evidence and differing views and weigh them appropriately in their decision-making[4]. With a growing number of outstanding DoLS referrals nationally[5] and pressures on Local Authorities to meet those demands the DoLS team at Cornwall Council have been keen to learn more about the time it takes BIAs to complete their assessments and to consider any 'time standards', other than those found in Schedule A1[6], they may have to work within.

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[1] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19 On appeal from [2011] EWCA Civ 1257; [2011] EWCA Civ 190

[2] In both England and Wales, BIA's must be either an AMHP, social worker, nurse, occupational therapist or chartered psychologist with the necessary skills and experience specified in the regulations.

[3] The Deprivation of Liberty Safeguards ("DoLS") was introduced in April 2009 and provide a means of protecting people who, for their own safety and in their own best interests, may need to be accommodated under care and treatment regimens that have the effect of depriving them of their liberty, but who lack the capacity to consent.

[4] The Deprivation of Liberty Safeguards: Code of Practice (2008) to supplement the main Mental Capacity Act 2005 (2008) at paragraphs 4.65 – 4.76 details the main responsibilities of the BIA.

[5] See Health & Social Care Information Centre. 2015., Deprivation of Liberty Safeguards (England), Annual Report 2014-15.

[6] H.M. Government., 2005., *Mental Capacity Act 2005 (C. 9).* London: HMSO.

The Literature

In 2008 the Mental Health (Amendment) Act (2007) ("MHAA") implemented new legislative reforms. These amendments also heralded the introduction of the Deprivation of Liberty Safeguards ("DoLS"). Implemented in April 2009, the DoLS are an amendment to the 2005 Mental Capacity Act (MCA)[7] and provides an expansion in the legal framework for decision-making in the face of limited capacity. The DoLS (subject to certain criteria) allows for restrictive care regimes to be authorised within general hospitals and registered care homes.

Following the introduction of the DoLS, the literature suggests there has been little clarity to guide practice in the assessment of deprivation, an area that has been fraught with difficulties for assessors[8] and indeed for the Courts[9]. Much debate ensued as to the salient features that might constitute a deprivation of liberty both here in the UK and in the European Courts. Despite this, commentary in the contemporary evidence base sees a dominant discourse for change; with strong evidence that the DoLS scheme is 'not fit for purpose'[10]. The bureaucratic burden on local authorities' figures largely in these debates, a matter recognised by the House of Lords Select Committee in their post-legislative scrutiny of the Mental Capacity Act ("MCA") published in March 2014. In their report the Select Committee strongly emphasise the need to challenge the *"unnecessarily bureaucratic and cumbersome"* procedures associated with the DoLS scheme and strongly recommend that the government undertake a comprehensive review of the DoLS legislation with a view to replacing it[11].

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[7] Following HL V UK ("Bournewood") (see HL v UK 45508/99 (2004) ECHR 471)

[8] Cairns, R., Brown, P., Grant-Peterkin, H., R.Kondokher, M., Owen, G. S., Richardson, G., Szmukler, G., Hotopf., M., 2011. *Judgement about Deprivation of Liberty Made By Various Professionals: A Comparison Study*. The Psychiatrist. Issue 35. pp344 – 349.

[9] See Cheshire West and Chester Council v P (2011) EWCA Civ 1257

[10] House of Lords. 2014., Mental Capacity Act 2005 – Post-Legislative Scrutiny. Select Committee on the Mental Capacity Act 2005. House of Lords. TSO: London.

[11] Ibid

In March 2014, the same month as the House of Lords Select Committee published their report; the long anticipated judgment in the case of Cheshire West was handed down by the Supreme Court. The critical question before the Court is helpfully summarised by Ruck-Keene[12] who observes;

> *"does liberty mean something different to an adult who is (for reasons of disability) unable to take advantage of it? Or does liberty mean the same for all?"*

Lady Justice Hale makes it very clear that that people with disabilities (both mental and physical) *must* have the same protective human rights *"as the rest of the human race"*[13]. She goes on to remind us that human rights are inherent and this places obligations upon the state (and others). She held that an 'acid test' should be used when considering P's (the person) concrete situation, where the key points are;

i. *that the person concerned was under continuous supervision and control and;*

ii. *is not free to leave*

The impact of the Cheshire West judgment effectively broadened the qualifying criteria for the DoLS and brought an almost immediate upsurge in requests to local authorities, and many have been unable to manage the rapid groundswell in authorisation requests. The first annual statistics[14] published by the Health & Information Centre in September 2015 reports that there has been a *"tenfold increase"* in new referrals, with 137,540 DoLS applications received by councils between 1st April 2014 and 31st

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[12] Ruck-Keene, A., 2014. 'Cheshire West: the Supreme Court's right hook'. Mental Capacity Law and Policy 19/03/14. Available From: http://www.mentalcapacitylawandpolicy.org.uk/cheshire-west-the-supreme-courts-right-hook/

[13] *Re Cheshire West and Chester Council v P* (2014) UKSC 19, (2014) MHLO 16

[14] See Health & Social Care Information Centre. 2015., Deprivation of Liberty Safeguards (England), Annual Report 2014-15.

March 2015. Significantly these figures also demonstrate an incremental increase for outstanding applications which by the 31st March 2015 stood at 67%.

The impact of this change upon local authorities, whose role it is to oversee the DoLS, is tremendously challenging. With concerns for the future viability of the DoLS scheme, the Law Commission have published a consultation paper[15] to consider how the law should regulate deprivations of liberty. Issued for discussion in July 2015 the Law Commission stresses the importance of *"a high degree of engagement with stakeholders"*, including Best Interests Assessors and DoLS leads throughout England and Wales. Although the outcome of this consultation is not yet known, it is clear that any change is likely to take several years and require close legal scrutiny and Government approval.

A critical analysis of the literature contiguous to the DoLS suggests a dearth of evidence as to the impact of these changes on BIAs. In a bid to manage the increased pressures since Cheshire West local authorities report they are employing various strategies to cope with the sudden rise in demand for DoLS assessments[16]. Many local authorities have looked to enlarge their pool of qualified BIAs, increase caseloads and form specialist DoLS teams in a bid to manage the increased demand for DoLS assessments. A report published by Community Care in October 2014 suggests that local authorities are estimating each the DoLS assessment takes, on average, between 10 and 15 hours depending on complexity[17]. The time it takes to complete a DoLS assessment is becoming an area of increasing interest as local authorities seek ways to enhance their productivity.

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[15] The Law Commission. 2015., Mental Capacity and Deprivation of Liberty: A Consultation Paper [paper 222]. The Stationary Office: London.

[16] Community Care. 2014., Six ways councils are trying to combat a shortage of best interests assessors. October 1st 2014.

[17] Ibid

For the most part, there appears to be very little evidence about how the DoLS procedures, including issues of bureaucracy and pressures in terms of productivity, might impact upon BIAs. Whilst the Cheshire West judgment has brought with it significant changes to practice, less is known about BIAs and their individual experiences. To advance the evidence base, the DoLS team at Cornwall Council have embarked upon a focused research study to analyse the time it takes BIAs to complete their assessments and to consider any 'time standards' they may have to work within. With a focus on practice development the project outcomes have been set to create an 'optimal culture' for learning. This sees us taking a *national* rather than local approach to the study, with a clear commitment to practice development in the broad sharing and dissemination of this report, a practice seen as vital in enabling the evolution of quality improvement in practice[18].

[18] McSherry, R. & Warr, J. 2006., *Practice Development: Confirming the existence of a knowledge and evidence base. Practice Development In Health Care*, Vol. 5, No. 2, pp 55-79.

Section two

Methodology & Research Design

Ontology, epistemology and design

The 'research phase' has been driven by quantitative research methods utilising a survey design. Meaning has been reinforced by introducing a qualitative element into the survey design as this was felt to be critical in 'rounding' and bringing meaning to the statistical data.

We chose an online survey design as this method of data collection is relatively easy to access and to develop. It is also cost effective and offers the opportunity to gather a broad range of data with considerable reach in terms of accessibility via social media in extending the sample size.

Sampling and population

Whole population relevance is not the purpose of this study; relevance is to Best Interests Assessors ("BIA") and their selection is made as a 'specific target group'. By taking a 'purposive'[19] approach to sampling the data generated, validity is increased by taking a random selection of respondents within the specified sample. We achieved this by making contact with the respondents through the use of social media either directly or via specialist sites (e.g., Twitter, Facebook, specialist bloggers and organisations) this generated greater opportunity for random selection and mitigated against the introduction of researcher bias into the sample selection.

[19] Purposive sampling employs methods to ensure individual participants have the necessary characteristics (e.g, role profile, knowledge and experience) appropriate to answering the overall research question.

Ethics and methods for engaging participants

The survey design is entirely confidential. No personally identifiable information was requested or taken. Participants were given detailed written information at the beginning of the survey, including a brief confidentiality statement. Data storage is secure and data will be available for one year following the publication of this report. Participant engagement was made via local professional teams and networks and using social media. Participant consent is assumed upon beginning/completing the online survey.

Piloting and Timescale

An initial pilot of the survey was made in July 2015 with respondents who fitted the sample criteria. Eight surveys were completed and minor adjustments were made to wording and to the question structure to refine the survey. The study began on the 30th July 2015 for three weeks to the 21st August 2015. Whilst the study time-scale was regulated; we chose to extend online access for a short period to the 4th September 2015 to account for the time of year, and allowing potential respondents greater opportunity to reply over the busy summer holiday period.

Data organisation, analysis and evaluation

18 survey questions were asked around four core themes – current practice, professional background, employer background and the time taken by the BIA to complete a DoLS Assessment. We broke the time taken to complete a DoLS Assessment in to fourteen 'key stages', identified as critical phases in undertaking a DoLS assessment.

Transferability and Limitations

In taking a survey approach the aim of the study has been to enhance its validity and its overall generalisability. Whilst surveys offer a quick and cost effective means of generating large amounts of data, surveys also have significant limitations when used as a tool to measure the social world. For example, when recalling from a specific past event survey respondents may not necessarily recall accurately what they did or as how the event actually happened.

To try to limit inaccuracy and enhance validity the study takes a particular focus on 'time' (minutes and hours) offering respondents a universal and measurable concept upon which to base their responses, an approach that aims to limit issues with accuracy in reporting. To support this, the questions where carefully structured to follow the general course or 'key stages' of a DoLS assessment, the trajectory being similar for both an initial assessment for re-assessment for a further period of authorisation.

The findings suggest a small percentage of respondents have skipped questions where the preceding answers would suggest an answer would have been generated. This is discussed in the 'main findings' (below). Any missing data appears to be entirely random and the authors have not felt it necessary to use methods such to revaluate or substitute the mean to 'reduce' the core data. The results are seen mainly in tight clusters ('bell shaped' results on the graph) this gives confidence in the variance and of the survey design as a reliable measure. To enhance this further we also provided space for 'free narrative' this has been used to offers a higher degree of description and to increased depth of meaning for the study overall.

Section three

Results

Organisation of results

The organisation of the results in this chapter has been made according to the flow of the questions in the original survey. There are 18 questions which are structured to follow the general flow or 'stages' of a DoLS assessment.

Each survey question is considered with reference to the original data which can be found in Appendix One, p51. Percentages have been rounded[20] (up/down) to the nearest whole value to enhance clarity.

Original statistical data has been analysed with focus on the overall percentage response and where applicable the 'mean' responses. Analysis has been made with a consideration of the standard deviation (i.e., how far responses vary or "deviate" from the mean). Statistical data is published in the appendices and are represented in the main findings. Original narrative data has been evaluated using thematic analysis and a 'Thematic Map' is published in Appendix One, p51 and narrative 'vignettes' are utilised alongside the main findings.

Response Rates

The overall response rate was 507[21] respondents. We felt this to be reasonably high given that the sample required a specialist professional background when taken in comparison to other similar professional studies.

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[20] *Due to rounding, some totals may not correspond exactly with the sum of the separate figures*

Main Findings

Question One – *"I am a practicing…"*

Of the 507 Best Interests Assessor ("BIA") respondents who took part in the survey 70% (353 respondents) tell us they are currently practicing as Best Interests Assessor (see Figure 1.0, Appendix 1, p52) and a further 30% (154 respondents) are working in a combined or 'duel' role as BIA *and* Approved Mental Health Professional ("AMHP").

Question Two – *"I am professionally qualified in…"*

In order to practice BIAs must be qualified in one of four professions. The survey revealed that of the 507 BIA respondents, 87% (443 respondents) are Social Workers; 9% (49 respondents) are Nurses; 4% (22 respondents) are Occupational Therapists and 1% (5 respondents) are Psychologists (see Figure 2.0, Appendix 1, p53) and of these 2% of the BIA respondents appear to be 'dual qualified' in more than one qualified profession.

Question Three - *"who do you work for?"*

Of the 507 BIA respondents, 5 (1% of respondents) skipped this question. The authors believe that it is likely the service descriptions used did not fit with the respondents own description of their employment, or that the respondents simply did not wish to disclose the information. Of the 502 BIA respondents who did reply 80% (394 respondents) tell us they work for a

[21] Given the confidence in the sample group the authors took a 95% confidence level, 0.5 standard deviation, confidence interval of +/- 5% and this suggested that a minimum of 385 respondents would enhance generalizability within the wider sample population.

Local Authority. This high response was to be expected given the statutory role of local authorities in administering and supervising DoLS. A further 21% (106 respondents) told us that they work in the independent sector, a figure significantly higher than the authors anticipated. A further 11% told us that they work for a health service (54 respondents); 0.4% (2 respondents) in the voluntary sector and 0.2% (1 respondent) in the charitable sector. The findings suggest that around 11% (54 respondents) reported working for more than one of the above agencies (see Figure 3.0, Appendix 1, p54).

Question Four - *"Consider a recent DoLS assessment you have undertaken. Which requirements were you asked to assess?"*

Of the 507 BIA respondents 19 (4% of respondents) skipped this question. Again this is a small percentage of the overall sample. It is felt likely that some respondents may have skipped the question as it did not apply to the work they undertook, for example where an assessment is not completed by the BIA (e.g., the person is found to have capacity by another assessor *or* the person is found to be ineligible by another assessor).

Of the 507 BIA respondents 488 (96 respondents) told us about a recent DOLS assessment (see Figure 4.0, Appendix 1, p55). A total of 99% (484 respondents) BIAs reported that they undertook the 'Best Interests Assessment', one of the six statutory assessments[22] for DoLS. The high response rate for this assessment was anticipated as the central role of the Best Interests Assessor is to establish, firstly, whether deprivation of liberty is occurring or is going to occur and, if so, whether it is in the best interests of the relevant person to be deprived of their liberty.[23]

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[22] Six assessments: Age, Mental Disorder, Mental Capacity, Eligibility, No Refusals and Best interests. Assessment of Eligibility requires the BIA is also qualified as an Approved Mental Health Professional ("AMHP"). Assessment of Mental Disorder can only be made by an 'approved' Doctor.

[23] The Deprivation of Liberty Safeguards: Code of Practice (2008) to supplement the main Mental Capacity Act 2005 (2008).

In the assessment of age 94% (459 respondents) of the BIAs told us that they also undertook the assessment of 'Age' (see Figure 4.0, Appendix 1, p55). The consideration of age is made in the context of DoLS is to confirm whether the relevant person is aged 18 or over. In terms of reporting the age assessment has often been included within the report for the 'Best Interest Assessment'.

A further 93% (452 respondents) of the BIAs also report making an assessment of 'No Refusals' to establish whether an authorisation under DoLS would conflict with any other existing authorities for decision-making (see Figure 4.0, Appendix 1, p55).

Of the BIA respondents 49% (241 respondents) tell us that they undertook an assessment of Mental Capacity (see Figure 4.0, Appendix 1, p55). The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to decide on their accommodation in the relevant hospital or care home or whether to be given care or treatment.

Of the BIA respondents 30% (145 respondents) reported undertaking an assessment of Eligibility (see Figure 4.0, Appendix 1, p55). This assessment relates to the relevant person's status, or potential status (e.g., 'liability for detention'), under the Mental Health Act 1983. The assessment of Eligibility can only be conducted by an AMHP or suitably qualified[24] doctor. The findings are therefore reflective of the limited role of the BIA who, unless qualified as AMHP, is not trained to assess for eligibility.

Question Five – *"Was this an initial (first) authorisation OR a re-assessment for a further period of authorisation?"*

Of the 507 respondents 488 (96% respondents) reported on the 'type' of assessment (see Figure 5.0, Appendix 1, p56). The choice between assessment 'type' was left to the respondents to decide. A total of 19 (4%)

[24] A doctor who is 'approved' under Section 12 of the Mental Health Act 1983 and is approved on behalf of the Secretary of State (or the Welsh Ministers) as having special expertise in the diagnosis and treatment of 'mental disorders'.

respondents skipped question five and we anticipate that our description of work type did not fit with the respondent's view or that they did not wish to disclose this information. Overall, of the 488 BIA respondents who answered the question, 79% (386 respondents) reported undertaking an initial or 'first' DoLS assessment, this figure is significantly high given that only 21% (102 respondents) reported on 're-authorisation', this appears to be low given that some authorisations are likely to generate further period of authorisation.

Question Six – *"In your opinion was this assessment 'complex' OR 'reasonably straightforward' (Use the ADASS Priority Criteria link to help with this rating if you wish)"*

Of the 507 BIA respondents 486 (96% respondents) told us about their 'complex' and 'straightforward' assessments. The findings for question six was split equally, with BIA respondents reporting on 50% (243 respondents) 'complex' and 50% 'reasonably straightforward' cases (see Figure 6.0, Appendix 1, p57). The authors believe that for the small number that skipped this question either the description of work 'type' was unclear and therefore misunderstood or that the description did not fit with the respondent's view of the work type. However of the 507 respondents 21 (4% of respondents) gave no answer, however question six anticipates the BIA respondent will take a view about the work.

Question Seven - *"Approximately how long did it take you to travel?"*

Of the 507 BIA respondents 479 (94%) reported on travelling time. However 28 (6%) respondents skipped question seven and we anticipate that for this small group travel time was not a factor necessary to their experience of assessment. The results for question seven are seen mainly in tight clusters ('bell shaped') on the graph (see Figure 7.0, Appendix 1, p58). Of the 479 who reported the 40% (191 of respondents) reported taking up to 30 minutes to travel, 45% (215 of respondents) up to 1-2

hours travelling time and 6% (30%) up to 2-3 hours travelling time. Interestingly, in the outlying range 3% (16 respondents) reported 10+ hours travel time.

In terms of analysing the findings for question seven, we have used the 'mean' or 'average' calculation to evaluate the time for travel (to/from/during a DoLS assessment) has been rounded to the nearest six minutes. The results suggest an average of:

66 minutes

Question Eight – *"Prior to your visit approximately how long did you spend gathering information/consulting with others?"*

Of the 507 BIA respondents 479 (94%) reported on how long they spent gathering information/consulting with others (see Figure 8.0, Appendix 1, p59). A total of 28 (6%) of respondents skipped question eight and we anticipate that this was not a factor necessary to their experience of assessment. Similarly to question seven the results here appear in tight clusters ('bell shaped') on the graph. Of the 479 BIA respondents 49% (236 respondents) report spending up to 1-2 hours gathering information/consulting with others prior to assessment. The spread of responses see peaks appear between 30 minutes (15%) and up to 3-4 hours 7% (33 respondents) and this accounts for 91% (435 respondents) of the overall responses.

In terms of analysing the findings for question eight, we have used the 'mean' or 'average' calculation to evaluate the time for gathering information/consulting with others prior to assessment (to/from/during a DoLS assessment) has been rounded to the nearest six minutes. The results suggest an average of:

90 minutes

Question Nine – *"Approximately how long did you spend at the hospital or care home checking or gathering information (e.g., consulting with P and others?)"*

Of the 507 BIA respondents 469 (93%) reported on how long they spent at the hospital or care home checking or gathering information (see Figure 9.0, Appendix 1, p60). A total of 38 (7%) respondents skipped question nine and we can only anticipate that this was not a factor necessary to their experience of the assessment. A question obviously arises from this, as consultation with the relevant person and others is statutorily required[25] and is a necessary part of a DoLS assessment. One reason for this could be that the assessment was stopped before this work was completed (e.g. if the person regains capacity or is found to be ineligible for the DoLS).

Of the 469 respondents 36% (169 respondents) reported spending 1-2 hours and a further 37% (175 respondents) reported spending 2-3 hours. The results for question nine appear again in tight clusters ('bell shaped') on the graph. The spread of responses see peaks appear at 1-2 hours and 4-5 hours in range, this accounts for 95% (445 respondents) of the overall responses. Interestingly, the outlying responses suggest that 1.0% (3 respondents) took 10+ hours at the hospital or care home checking or gathering information.

In terms of analysing the findings for question nine, we have used the 'mean' or 'average' calculation to evaluate the time for how long respondents spent at the hospital or care home checking or gathering information has been rounded to the nearest six minutes. The results suggest an average of:

126 Minutes

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[25] Section 4(7) of the Mental Capacity Act requires the BIA to seek the views of a range of people connected to the relevant person to find out whether they believe that depriving the relevant person of their liberty is, or would be, in the person's best interests (see also MCA Code of Practice, 2008, para 5.49).

Question Ten – *"Approximately, how long did you spend consulting with the mental health, capacity and/or eligibility assessor?"*

Of the 507 BIA respondents 469 (93%) reported on the time they spent consulting with the mental health, capacity and/or eligibility assessor (see Figure 10.0, Appendix 1, p61). A total of 38 (7%) respondents skipped this question and we anticipate this was not a factor necessary to the respondent's experience of assessment. One reason could be that the assessment was stopped before the work was completed (e.g. the person regains capacity or is found to be ineligible etc). Alternatively, the BIA respondents may themselves have been responsible for the assessment of capacity, and/or eligibility if they are suitably qualified. Likewise, direct consultation with the doctor is not a requirement for the BIA; they merely have to *"consider the conclusions"*[26] of the medic and do this the may elect to refer to written reports.

Of the 469 BIA respondents 71% (334 respondents) reported they spent up to 30 minutes consulting with the mental health, capacity and/or eligibility assessor and this is seen as a significant 'spike' in the spread of data.

In terms of analysing the findings for question ten, we have used the 'mean' or 'average' calculation to evaluate the time spent consulting with the mental health, capacity and/or eligibility assessor has been rounded to the nearest six minutes. The results suggest an average of:

48 minutes

Question Eleven – *"Approximately, how long did you spend gathering information and consulting with others after your visit to the hospital or care home?"*

Of the 507 BIA respondents 468 (92%) reported on the length of time spent gathering information and consulting after the visit to the hospital or care

[26] The Deprivation of Liberty Safeguards: Code of Practice (2008) at paragraph 4.70

home (see Figure 11.0, Appendix 1, p62). A total of 39 (8%) respondents skipped the question, and a further 2% (5 respondents) told us that they spent 0 hours gathering information and consulting with others after the visit, evidence that suggests this work was not a factor necessary to the respondent's experience of assessment.

Of the 468 BIA respondents 51% (238 respondents) report taking 1-2 hours gathering information and consulting with others after the visit to this hospital or care home. The results for question eleven sees the responses appear in tight clusters ('bell shaped') on the graph. The spread of responses sees the dominant peaks appear at 30 minutes 18% (83 respondents); 1-2 hours 51% (238 respondents); 2-3 hours 17% (79 respondents) and 3-4 hours 8% (39 respondents). The outlier results are significant with 1% (5 respondents) reporting 6-7 hours for this work.

In terms of analysing the findings for question eleven, we have used the 'mean' or 'average' calculation to evaluate the time spent gathering information and consulting with others after the visit to the hospital or care home has been rounded to the nearest six minutes. The results suggest an average of:

84 minutes

Question Twelve – *"Approximately, how long did you spend writing up all of the documents?"*

Of the 507 BIA respondents 469 (93%) reported on how long they spent writing up all of the documents. A total of 38 respondents (7%) skipped this question. Factors accounting for this omission appear to be few, as generally we would anticipate at least some record is kept unless DoLS assessments are withdrawn or fail to proceed. We can only anticipate that this was not a factor necessary to their experience of assessment or that the respondents did not wish to disclose this.

The findings in this question see the data spread more evenly across the graph and therefore we analyse a greater variability in respondent experience (see Figure 12.0, Appendix 1, p63). At the peak, 23% (108 respondents) BIAs report spending 2-3 hours writing up and the documents. However the outliers range from 1% (5 respondents) spending 30 minutes spend writing up all of the documents up to 7% (31 respondents) reporting 10+ hours. A number of conflicting and competing factors that we anticipate could account for the wide variability in response.

In terms of analysing the findings for question twelve, we have used the 'mean' or 'average' calculation to evaluate the time spent writing up all of the documents is rounded to the nearest six minutes. The results suggest an average of:

228 minutes

Question Thirteen– *"Approximately how long did you spend giving feedback to the Managing Authority?"*

Of the 507 BIA respondents 464 (92%) reported on how long they spent giving feedback to the Managing Authority. A total of 43 (8%) respondents skipped the question and 14% (66 respondents) reported they spent 0 hours on this work. Although there is a requirement in the Best Interests Assessment that the BIA speak to the Managing Authority about the care plan, in terms of offering 'feedback' the only requirement is one of 'good practice'[27], for example the BIA might speak to the MA about the setting of any conditions they may attach to an authorisation. We therefore expect that for the respondents who skipped question thirteen this was not a factor necessary to their experience of the assessment. Of the 464 BIA respondents who told us about how long they spent giving feedback to the Managing Authority the results show a significant 'spike' in the spread of the

[27] The Deprivation of Liberty Safeguards: Code of Practice (2008) at paragraph 4.75 states that it is considered good practice for the Best Interests Assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment.

results (see Figure 13.0, Appendix 1, p64). At the peak, 67% (313 of respondents) BIAs report taking up to 30 minutes undertaking this work. The spread of the data also appears skewed, with of the vast majority responses falling in the range of 0 hours to 1-2 hours for this work.

In terms of analysing the findings for question thirteen, we have used the 'mean' or 'average' calculation to evaluate how long the BIAs spent giving feedback to the Managing Authority is rounded to the nearest six minutes. The results suggest an average of:

42 minutes

Question Fourteen – *"Approximately, how long did you spend giving feedback to the Supervisory Body, care team or others?"*

Of the 507 BIA respondents 469 (93%) reported on how long they spent giving feedback to the Supervisory Body, care team or others. A total of 38 (7%) of respondents skipped the question and 25% (113 respondents) reported they spent 0 hours on this work. Significantly, providing verbal feedback to the Supervisory Body is not a necessary requirement of the DoLS[28]; rather it is the BIA's assessment report that should explain their conclusions and their reasons. Notwithstanding this, anecdotal evidence suggests that many BIAs spend time discussing the outcome of their assessment with the Supervisory Body, beyond that of their written reports. So, in asking this question, we are keen to understand more about this work.

Of the 469 BIA respondents 57% (266 respondents) report they spend up to 30 minutes giving feedback to the Supervisory Body, care team or others. The findings again show a significant 'spike' in the spread of the results (see Figure 14.0, Appendix 1, p65). The spread of the data is also appears skewed, with of the vast majority responses falling in the range of 0 hours to 1-2 hours for this work.

[28] The Deprivation of Liberty Safeguards: Code of Practice (2008) at paragraph 4.72

In terms of analysing the findings for question fourteen, we have used the 'mean' or 'average' calculation to evaluate how long the respondents spent giving feedback to the Supervisory Body, care team or others has been rounded to the nearest six minutes. The results suggest an average of:

42 minutes

Question Fifteen – *"Did you use the new Association of Directors of Adult Social Services ("ADASS") forms?"*

Of the 507 BIA respondents 467 (92%) reported on using the new Association of Directors of Adult Social Services ("ADASS") forms. A total of 40 (8%) of BIA respondents skipped the question and the authors anticipate that reporting/ recording may not have been a factor necessary to their experience of assessment.

Of the 467 BIA respondents 71% (330 respondents) stated YES they used the new Association of Directors of Adult Social Services ("ADASS") forms leaving 29% (137 respondents) who reported NO to this question (see Figure 15.0, Appendix 1, p66).

Question sixteen – *"Are the forms you used part of an electronic records system"*

Of the 507 BIA respondents 467 (92%) reported on using an electronic records system. A total of 40 (8%) respondents skipped the question, as did the same number for question fifteen and the authors anticipate that reporting/ recording may not have been a factor necessary to their experience of assessment.

Of the 467 BIA respondents who told if they used and electronic recording system 56% (261 respondents) reported YES with the remaining 44% (206 respondents) reporting NO (see Figure 16.0, Appendix 1, p67).

Question Seventeen – *"Has your employer set a 'time standard' for the completion of assessments?"*

Of the 507 BIA respondents 453 (89%) reported on 'time standards' in the completion of assessments. A total of 54 (11%) respondents skipped question seventeen. We anticipate that for some respondents 'time standards' may not have been a factor necessary to their experience of assessment. We also recognise an issue with language; where 'time-scale' could have been an alternative descriptor. By using 'time-standard' as descriptor we hoped to include those Supervisory Bodies where the expectation of BIAs includes a requirement that they complete a certain amount of DoLS assessments over a specific period of time.

Of the 453 BIA respondents 26% (120 respondents) reported YES, their employer had set a 'time standard' and 74% (333 respondents) reported NO, their employer had not set a 'time standard' for the completion of assessments (see Figure 17.0, Appendix 1, p68).

Question 18 – *"If yes, please indicate to the nearest hour how long you are given to complete a DoLS assessment?"*

Following on from question seventeen, of the 507 respondents 129 (25%) indicated to the nearest hour how long they are given to complete a DoLS assessment. A total of 378 (75%) skipped the question which is symptomatic of the findings in question seventeen. The results are spread widely across the graph between 0 hours to 20+ hours. Interestingly, the graph shows a broad spread of results with a no symmetrical central cluster ('bell shaped' results) (see Figure 18.0, Appendix 1, p69).

In terms of analysing the findings for question eighteen the 'mean' or 'average' calculation to evaluate nearest hour BIA's were given to complete a DoLS assessment is rounded. The results suggest this is an average of:

600 minutes (Ten hour) – time standard

Question nineteen – *"Is there anything else you would like to tell us?"*

Of the 507 BIA respondents 146 (29%) took the opportunity to tell us something else. This question was for 'free narrative', a qualitative approach that aims to add depth of meaning to the statistical data. The question was left open to encourage the respondents to answer with their own ideas. It was also left intentionally optional as a means to enhance the overall quality of the data, allowing respondents greater autonomy of choice when sharing their views.

Question 19 generated a significant amount of narrative data. A thematic analysis (Thematic Map, Appendix 2, p71) suggests 8 dominant themes, these are;

- Time
- Complexity
- Bureaucracy
- ADASS Forms
- Demography
- Travel
- Core Values
- Independence

These eight themes are presented here in more detail, with narrative 'vignettes' (verbatim monographs) used to enhance the data and to add depth of detail.

Time

Of the eight themes 'time' is of course an obvious factor; the overall premise of the study focusing on learning more about the time it takes BIAs to complete their assessments and to consider any 'time standards' they may have to work within. Of the 146 BIA respondents who commented 53% told us about themes attendant to 'time'.

Many of the BIAs told us about their working arrangements with their employer; this was seen as a significant factor in defining the 'timescale' of assessments. Their reports on these arrangements indicate working agreements to be highly variable and this would support the data seen at questions seventeen (p68) and eighteen (p69). Here three BIAs make reference to this;

BIA A

> *"We are not given a set time for individual assessments but are expected to do 4 assessments a week as a full time BIA who spends 1 day as an AMHP..."*

BIA B

> *"For a full time worker the target is 3 initial assessments per week, or 5 reviews, or a combination. A business plan that is target driven."*

BIA C

> *"21 days is the turn around from point of allocation, so 15 working days. Dedicated BIA's are expected to complete 2-3 p/week depending on complexity…"*

Conversely, some BIAs report they are bound only by the statutory guidelines set for standard or urgent authorisations[29]. For this group, where we see a predominance of independents, there appears a much greater sense that the time given by Supervisory Bodies to complete the work must be reflective of its importance in the lives of people.

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[29] Standard DoLS Authorisations up to 7 days to assess
Urgent DoLS Authorisations up to21 days to assess

Independent BIAs also told us that their fees (often decided at the beginning of the work) are paid regardless of the time spent on assessment. Several independents indicated concern for their counterparts working in local authorities citing concern for increased time pressures, as this BIA suggests;

BIA D

> *"I work independently. On a recent visit to a care home after spending 45 minutes going through the case file the manager said to me … a lot of BIA'S only spend 10 / 15 minutes an assessment. I suspected they are under pressure from their employer to complete the assessment. To me it is essential that the BIA takes the amount of time they think any individual assessment requires."*

The subthemes suggest that some BIAs are frequently completing DoLS work in their own time, and without adequate pay. Equally, others are reporting that the time given to complete their assessments is wholly insufficient, even when they are offered remuneration (e.g., limited overtime payments). These three BIA respondents told us;

BIA E

> *"I have one day to complete all the work for DOLS assessment, after this it has to be completed in my own time."*

BIA F

> *"Often takes longer than the allocated day on the rota and is always a long intense day".*

BIA G

> *"I'm paid for 7 hours but each assessment takes at least 11 hours"*

A lack of consistency in the approach to the overall management of DoLS between local authorities and their Supervisory Bodies was an appreciable subtheme in the context of 'time'. This was reported by independents who might work for several local authorities, for example these two BIAs told us;

BIA H

> *"As I work for both a local authority and do some independent assessments it is noticeable how different authorities have very different approaches to the work. The length of assessments can vary greatly depending on the circumstances."*

BIA I

> *"I am concerned that there may be objectives regarding quantity v quality of assessment. Independent BIAs are accountable for their own work, and need to be satisfied that if held accountable, they can justify their assessments and any recommendations/conditions. If a Supervisory Body stated a required timeframe, shorter than 7 or 21 days required by law, than this may make the BIA vulnerable of making less efficient assessments and judgements."*

In analysing the predominant subthemes our BIA respondents suggest that the time it takes them to complete DoLS assessments is greatly dependent upon their BIA role such as; who they work for (e.g. the Supervisory Body and its own procedures and expectations) and the sphere of activity and overall complexity of the work. This variance in common experience is evident in the main statistical findings and suggests that the work of BIAs is affected by the differing operational objectives of Supervisory Bodies, a theme that continues herein.

Complexity

Of the 146 BIAs who responded to the open question 36% (53 respondents) told us about 'complexity' or themes associated with complexity in their DoLS work. The dictionary definition for the word 'complex' is: *"The state or quality of being intricate or complicated*". We used this definition as a guide within the thematic analysis for reference of both the word "complex" and "complexity" to identify subthemes associated with complex working arrangements in the respondent's narrative.

For many of the BIAs it appears that the complexity of the work is regarded as a key determining factor in influencing the timescale of a DoLS assessment. This is summed up clearly by this BIA;

BIA J

> *"Assessments are complex, the time needed to consult is critical. Supporting engagement in consultation always requires careful conversations about the assessment and the need for this type of legal authority. AMHPs May also need to undertake eligibility assessments and the balance between the MCA and MHA requires careful consideration. This cant be rushed, and nor should it be, the risk of time standards outside that of the statutory scheme is frankly dangerous, risking 'corner cutting' and poor professional judgments. More importantly, the risk of eroding professional independence in the planning of assessments that practitioners will be called in to account."*

BIA K

> *"Unfortunately, most of the complex cases that I have encountered came with very inadequate care plan that ignore the fourth and fifth principles of the MCA i.e. best interests and least restrictive option possible. In order to adhere to the 2nd principle of the MCA, I have to demonstrate the support that I have given to the relevant person in establishing whether he or she is able to give valid consent to the placement. Certainly, I think it is not best practice to arrive and tell the relevant person that I am here to assess your capacity without trying to build some kind of a rapport and this is where reading the background information of the person concerned can help. If care management/planning are done correctly and in full compliance of the MCA, the job of the BIA will be much much easier and quicker."*

Complexity is also seen as a barrier to setting 'time standards', this is seen by BIA respondents to be highly dependent upon the individual circumstances of the case, including a number of other variables such as consultation and assessments by others (e.g. doctors), this is observed by two BIA respondents;

BIA L

> *"I have found the total working time to complete a DOLs Assessment is variable from 12 hours to 5 days dependent on the complexity of the case, level of detail required by the supervisory body, amount of people to be consulted, access to information, chronology and factors to be considered around least restrictive options. If a case is likely to or being contested through the COP it is likely to take longer than the 19 hours allocated."*

BIA M

> *"Assessments can be extremely variable* [in time] *from setting up a visit to seeing the person and contacting relevant people. Sometimes, owing to communication problems in particular, it is necessary to see a person on more than one occasion to be able to assess capacity with confidence."*

What is clear from the BIA respondents is that the variability in cases from 'more straight forward' to 'complex' has a significant impact on how BIAs perceive the work, and in some cases it appears their approach to it, this includes the overall time they might invest in the assessment.

Bureaucracy

We found 'bureaucracy' to be a notable theme in the narrative responses. This is not unexpected given the contemporary discourse surrounding DoLS where the procedure is regarded as "deeply flawed"[30]. Many of the BIA respondents referred to bureaucracy in terms of the 'processes' of assessment (e.g., recording, management/administration) and this tension adding to the overall complexity of the work. This is observed by two BIAs who told us;

BIA N

> *"To me the whole framework has become overly involved and bureaucratic, to meet an actually relatively simple aim!"*

BIA O

> *"Information gathering takes a lot of time, checking documents writing up is not something you can do quickly. I can do them quickly but would be missing lots of issues re restrictions and care plans. Also contacting relatives and including their views can take a lot of time. Researching medication and less restrictive options, seeking advice from a pharmacist. It's a large piece of complex work. Then we have to sort rpr and complete a care plan. It's un sustainable. Lots more tasks on top. I think it takes twice as long as people are saying. People don't want to admit they are struggling."*

For other BIAs, bureaucracy is seen in terms of DoLS and its complex processes are perceived by the person and their family, as this BIA observes;

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[30] The Law Commission. 2015., Mental Capacity and Deprivation of Liberty: A Consultation Paper [paper 222]. The Stationary Office: London.

BIA P

> *"Since Cheshire West, It has become more complex. Previously, it was quite easy and straightforward. In my experience most of the people I was assessing their families were very involved in their care. Now even if family are very involved the DOLS needs to be authorised. Many families do not understand why this has to happen. They see themselves as being involved in their family members care and would speak up if they felt there was anything they were unhappy with. Many families have told me they see it as added bureaucracy and do not understand why it has to be applied. Even after explaining it to them, they say I know you have to do your job but my mum/dad has not been able to tell you what they wanted for a number of years. Some have even gone as far as to say, we are told there is no money, yet they have workers going round doing things like this and in their view a complete waste of time and money."*

ADASS Forms

Further to concerns for bureaucracy, of the 146 BIAs who replied to this question, 21% (31 respondents) told us about reporting and more specifically about the current Association of Directors of Social Services ("ADASS") forms for recording assessments. Their responses to this subtheme are highly variable; with a clear split between those BIAs who indicated the new forms are an 'improvement' and those that told us they are 'repetitive' and 'time consuming'. This is reported by four BIAs;

BIA Q

> *"The new ADASS forms make write ups a lot smoother and quicker, however dealing with the administration element of the process is still very time consuming."*

BIA R

> *"The current forms are an improvement on the original forms but could still be improved with less repetition."*

BIA S

> *"Since changing to the new forms it is taking me 2 - 3 times as long as previously and I feel they are quite repetitive in areas."*

BIA T

> *"The new forms are a nightmare to work with, repetition repetition repetition, same information put into different context. Loathe them."*

Overall, for the BIAs who told us about the new ADASS forms several suggested that with some 'tweaks' to the format the new recording documents can help to guide thinking, particularly with regard to structuring the evidence.

Demography and travel

Demographics and travel time are also seen by the BIA respondents as prominent themes, with some reporting to us that these factors can add considerably to the overall time assessments take, this is highlighted by these BIA respondents;

BIA U

> *"Another aspect of the work which can take up much time is travel. I have done a number of assessments in out counties (out of area placements) involving a 2.5h drive one way…"*

BIA V

> *"Travel time needs to be seriously factored into the assessment time period as does unforeseen circumstances…"*

Some BIAs also told us that factors like travel add to the pressures placed on them by Supervisory Bodies, as is observed by this BIA;

BIA W

> *"Distance is also a factor as I have travelled for up to 6 hours before to get to a visit. Personally I do feel pressured by the SB to get through the assessments in a time frame."*

Travel is seen by some BIA respondents as a factor that is somewhat overlooked by Supervisory Bodies. Some BIAs report that they work with narrow time standards where with little regard has been paid to travelling time.

Core Values and independence

It is clear from the BIA respondents' narrative responses that professionally they hold values consistent with core capabilities[31] in their assessor role. Some BIAs noted concerns that 'time standards' add additional pressures, this BIA respondent fears that it is forcing assessors to take 'short-cuts';

[31] In 2012 the College of Social Work authored a suite of six practice 'capabilities' that set out the minimum expectations for qualified BIAs when fulfilling their role under the Deprivation of Liberty Safeguards (DoLS). The capabilities are a set of good practice standards that BIAs are expected to meet and are part of the wider the Professionals Capabilities Framework (PCF).

BIA X

> *"Since Cheshire West, I believe that BIAs are being pressured in to taking short-cuts and do not scrutinise the records or validate the information as thoroughly as they have done previously. I receive this feedback from BIA's and managing authorities which I train extensively."*

Many of the BIA respondents indicated to us that whilst 'time standards' might suit Supervisory Bodies, by helping to increase productivity in the face of the Cheshire West ruling, such working arrangements place pressures on them as assessors with the risk of eroding their independence[32] in decision-making, as this BIA observes;

BIA Y

> *"I am concerned that there may be objectives regarding quantity v quality of assessment. Independent BIAs are accountable for their own work, and need to be satisfied that if held accountable, they can justify their assessment and any recommendations/conditions. If the supervisory body stated a required time frame shouter than the 7 or 21 days required by law, then this may make the BIA vulnerable of making less efficient"*

Others cite concern for 'time standards' and their professional independence as direct employees of the Supervisory Body, as this BIA points out;

BIA Z

> *"The time standards appear arbitrary, i.e. not based on the legal timeframe; and there is more focus on meeting the time frame than on the quality of assessments and sufficient time being given for this. I work full time as a BIA and my direct line manager/supervisor is the MCA DoLS lead which I feel brings in to question the independence of the BIA".*

[32] The Deprivation of Liberty Safeguards: Code of Practice (2008) at paragraph 4.66 states *"It is essential that the best interests assessor provides an independent and objective view of whether or not there is a genuine justification for deprivation of liberty, taking account of all the relevant views and factors"*.

Further to this subtheme is the effect upon their independent role in providing a voice the relevant person at the centre of the assessment, as this BIA points out;

BIA Ab

> *"Whilst I appreciate the need for standardised approach, as with all human services no one case is ever the same as the last. Information gathering is not a start to finish process and often the approach is fractured not continuous. I have concerns that addition pressures will apply to a rationalised approach and loose a) the quality of the assessment approach, and (more importantly) b) the voice of the person subject to the assessment will be lost in time constrained approach."*

Despite pressures, many of our BIA respondents noted concern that in making best-interest decisions (within the context of a DoLS assessment) their ability to effectively analyse complex situations and make proportionate decisions is very much rooted in their independent role.

Summary of BIA narratives

The narrative responses of the BIA respondents have helped us in analysis by adding meaning and depth to the statistical data which we refer to more in the discussion and reflection (p41). The BIAs responses point to some important themes and sub-themes that go beyond just the issue of 'time' and that would warrant further scrutiny through future research study.

Section four

Discussion & Reflection

The question of how long it takes BIAs to complete their DoLS assessments appears to have taken on much greater significance in the period following Cheshire West. Whilst the Law Commission proposes a new scheme (the timeframe for any draft legislation is set for late 2016) it is anticipated that any new legal powers are unlikely to be implemented until at least 2018. In the interim, with evidence that the DoLS scheme is unable to cope; many local authorities are seeking strategies to manage increased demand for DoLS authorisations. To manage this the Directors of Adult Social Services ("ADASS") have published guidance to support local authorities to develop their businesses, however the pressures faced by many Supervisory Bodies has seen an overwhelming burden placed upon their (often) limited services.

In this study we found that a high percentage of the BIA respondents are Social Work qualified (87%). This was expected, the study shows that a majority of BIAs work for and will be trained by local authorities (78%), who as the Supervisory Bodies, will often draw from their pool of Social Worker employees. To meet the increased demand for the DoLS authorisations we would expect this professional pool of BIAs to increase. We were surprised by the low number of AMHP/BIAs who responded (30%) and have considered this in terms of their training and their role. Whilst most AMHPs are employed by Local Authorities many are seconded under special legal arrangements[33] to work under NHS management in mental

[33] An agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

health trusts. We speculate that whilst the new AMHP course provides a component for BIA training, it may not be seen as critical for health managers to allow their AMHPs to practice for the local authority when they too are faced with significant assessment and care-coordination pressures. Whilst this may not be true for all AMHPs or teams, evidence[34] suggests that some local authorities are re-considering the legal arrangements for their mental health social workers, with some reporting that they have terminated the partnerships in recent years[35]. We would anticipate that in light of additional service pressures since Cheshire West that the AMHP role, in managing increased demand for DoLS, would also form part of that consideration for local authorities.

The findings also show a low proportion of other health professionals (e.g. nurses, occupational therapists and psychologists) practicing as BIAs (15%), whilst we have found no evidence (in other studies) to better support our understanding of this, we would speculate that these numbers have always been relatively low. One factor in this can be found in the arrangements for of Supervisory Bodies, a role that now falls to local authorities and provides no supervisory role for local health commissioners. We believe that this shift will see even less impetus for health services to provide BIA training opportunities for their staff (who would effectively be working for the Local Authority) and that numbers will remain low unless there is a change to the current scheme. Whilst we speculate on this, we feel strongly that a professional mix of assessors brings many benefits to the Supervisory Body, none more so than having a broad and diverse pool of professional skills upon which to draw from.

Not all of the BIA respondents are employees of a local authority or health service. With only 11% working for the health services, a very small percentage (0.60%) told us they are from the charitable/voluntary sectors.

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[34] Community Care, 2013., *Councils split on integration of mental health social workers in NHS.* Accessible from: http://www.communitycare.co.uk/blogs/mental-health/2013/09/councils-split-on-full-integration-of-mental-health-social-workers-in-nhs/

[35] Ibid.

Notwithstanding this, we found that a 21% are independent BIAs; a significant number that we expect has increased since Cheshire West. With a sudden and much greater need for qualified assessors, to alleviate the pressures, many local authorities have turned to independent BIAs as a means to find a solution to assessment backlogs in their areas. Many Independents told us that they charge a 'flat rate' for their work, regardless of the time an assessment takes. The publication of the DoLS Annual Report 2014-2015[36] suggests significant increases in outstanding or unauthorised assessments, we would speculate that this will have a direct and positive impact on the work of independents and this could see their numbers rise further. Whilst we are unable to speculate from our findings what will happen to these sources of assessment work for independent BIAs when the DoLS is replaced, we can see from the findings that they appears to be filling an important gap in skills and experience in the application of the DoLS.

In analysing the data it is important to understand for each DoLS assessment there can be a high degree of variability. When considering how long it takes BIAs to complete a DoLS assessment we found that certain early or 'preliminary' variables are critical, these include:

- Whether the work is an 'initial' *or* 're-assessment' for a further period of authorisation
- The type(s) of assessment required (Best Interest, Age, No Refusals, Eligibility and Capacity)
- The predicted level of difficulty or 'complexity' of the work

We contend that these 'preliminary variables' exist on receipt of a DoLS referral and are evident *before* the assessment phase begins. We believe these variables are critical to Supervisory Bodies who can use this information to determine case management techniques such as 'triage'. For

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[36] See Health & Social Care Information Centre. 2015., Deprivation of Liberty Safeguards (England), Annual Report 2014-15.

BIAs, the narrative findings suggest that preliminary variables provide them with an early indication of the 'trajectory' of a DoLS assessment, from which they are better able to predict the scope of the work in terms of assessment time.

In looking at the first of these preliminary variables the findings tell us that 79% of the BIA respondents reported undertaking an initial or 'first' DoLS assessment. We believe this is an important variable when considering the overall time taken to complete the DoLS assessment. We speculated that 'initial' assessments would feature high in terms of the percentages and this was borne out. We would argue that the high proportion of initial assessments seen in the findings are certainly a reflection of the assessment pressures faced since Cheshire West, with high number of new applications being reported nationally. We would anticipate there will be an increase in 're-assessments', as initial DoLS authorisations lapse requiring assessment for a further period of authorisation. This will of course be dependent upon local authorities and their Supervisory Bodies, and the measures they will take to manage and prioritise outstanding authorisation requests and re-assessments.

In terms of the second preliminary variable, the findings also suggest that almost all of the BIA respondents completed a Best Interests Assessment as part of their assessment role (99%). Less BIA respondents undertook the Age assessment (94%) and it is not clear why, as this assessment is routinely contained within the same recording documents. We can only speculate that 'equivalents' were used or that this assessment did apply. Generally, BIAs and BIA/AMHPs can have up to five assessments to complete for any one DoLS case. The work is however dependent on the need for assessment (e.g, the relevant person's eligibility, capacity etc); the BIA's qualifications to assess and the arrangements local authorities have, which appear to vary widely from one authority to another. The findings for all five assessments (Best Interest, Age, No Refusals, Eligibility and Capacity) clearly reflect the choice within the statutory framework, where

professionals other than BIAs (e.g. AMHP, AMHP/BIA or suitably qualified Doctor) can also undertake assessments of capacity and eligibility for the DoLS. For re-authorisations or a further period of DoLS, Supervisory Bodies can also rely upon using 'equivalent assessments'[37]. We anticipate that in our findings a proportion of the assessments relied on 'equivalents' and this will reflect greatly upon the time taken by the BIA.

Along with assessment 'type(s)' the complexity of the work appears to be a significant preliminary variable in determining assessment timescales. We recognise there is subjectivity when deciding on case complexity, so we employed the use of the Association of Directors of Social Services ("ADASS") 'priority criteria'. We used this to assist the BIA respondents in measuring complexity and to provide continuity to the findings. We also employed words ('complex' and 'reasonably straightforward'), words commonplace in many health and social care settings, to assist the BIA respondents in their choice. The findings suggest a 50/50 (%) split in BIA response as to whether they considered the work to be 'complex' or 'reasonably straightforward'. In looking at these findings, alongside the most recent national figures for DoLS, we would question how local 'triage' or prioritising systems factor in this? If 'triaging' is being implemented across local authorities we would of expect to see a greater percentage of BIAs reporting on more complex cases. The split in the findings could suggest that some local authorities are completing a majority of DoLS assessments so they have time to complete both complex and less complex cases, certainly the most recent data suggests that some geographic areas are performing better than others in completing their DoLS authorisations[38].

[37] As assessment that has already been obtained, under certain circumstances may be relied upon instead of obtaining a fresh assessment.

[38] See Health & Social Care Information Centre. 2015., Deprivation of Liberty Safeguards (England), Annual Report 2014-15.

Moving on from the preliminary variables, we focused on the 'primary components' of the BIAs work when undertaking a DoLS assessment (see Appendix 1 questions 7 to question 14). These components are described in the relevant Code(s) of Practice[39] and through anecdotal reports from BIAs. This work includes:

- Travel
- Information gathering (pre and post the visit)
- Consulting with the Managing Authority, the Relevant Person and others
- Time spent at the care home or hospital
- Consulting other assessors
- Feeding back (Managing Authority and Supervisory Body)
- Recording

We found these 'primary components' of the BIA's work also to be subject to significant variables, notably those driven by the process of the assessment including: any special requirements of the Supervisory Body, distance of travel, the type(s) of assessment required and the difficulty or 'complexity' of the work as this unfolds. An example of this is seen in Question 12 (see findings for Question 12 p24 and Appendix 1, p63) where we asked, *"Approximately how long did you spend writing up all of the documents?".* The spread of the results clearly indicates to us a reasonably high deviation from the 'mean' or 'average' and this nonconformity is a good indication of a high variance. This is notable when we look at the breadth and the range of responses. For example, at the lower end of the scale some respondents (2%) reported taking only 30 minutes recording time, however at the top end other (5%) reported taking up to 10+ hours in recording time. This variability in the BIA respondent's experience is therefore an important consideration when bearing in mind the data, particularly when we take a focus on the 'average' time it takes to complete

[39] See Code of Practice to the Mental Capacity Act (2007); Deprivation of Liberty safeguards Code of Practice (2008); Mental Health Act (1983) Code of Practice (2015).

a DoLS assessment. The average is only a measure of the central tendency and *must* be considered against all other variables, as the average can be skewed by outliers. In this respect the 'mean' or 'average' time can never be entirely indicative of every DoLS assessment as this is dependent upon how the many variables interact.

By providing a 'mean' or 'average' to consider the time it takes BIAs to undertake a DoLS assessment our aim is to offer a representative sample of the data. By taking the average findings from the study relevant to time the 'mean' or 'average' time for a DoLS assessment is:

12.1 hours (726 minutes)

It is likely that this average time will be of interest to BIAs and Supervisory bodies alike. Our research with the BIAs suggests that varying strategies are being adopted by local authorities, in their role as Supervisory Bodies, to cope with the increased demand for DoLS authorisations; this includes (for some) the implementation of 'time standards'. We found that 26% of the BIA respondents reported that their employer had set a 'time standard' for the completion of DoLS assessments. In the narrative data 53% of the them told us about 'time', with many citing an increased emphasis on assessment productivity and 'time standard' measures with their employer. Their responses suggest a high variability in those arrangements, this appears to be dependent on how many hours or shifts the BIAs are contracted to work, including whether their employer is the Supervisory Body or whether they have some other type of working arrangement (e.g. independents). For other BIAs, 'time standards' appear to be dependent upon how many assessments they are expected to complete each day or week they are scheduled to work. Some BIAs who are employed directly by the local authorities report a concern for increased time pressures in the wake of Cheshire West. Many suggest that they are not given enough time by their employers to complete assessments, particularly when their work as a BIA is not their primary or 'core' role. For some, this results in having to work in their own time to meet assessment timescales. Certainly, if we

were to apply the average assessment time found in this study of 12.1 hours, it is evident that the scope of the work exceeds an average 7.4 hour working day (as part of an average 37 hour working week). It therefore follows that some BIAs will experience difficulties in meeting assessment deadlines, particularly when faced with any limited ‘time standards’ that arise as part of their working arrangements.

We found that that BIA respondents’ experience of time and how long it takes to undertake a DoLS assessment is seen, not in terms of ‘time and task’, but in terms of the ‘complexity’ of the work and the bureaucracy of the scheme. This also appears to be accepted (at least to some extent) as ‘part and parcel’ of the work, along with other variables such as travel and delays in consultation. These areas are seen as critical to BIAs when defining the time it takes them to complete a DoLS assessment. Some BIAs suggest that their judgment of the work and its ‘complexity’ can sit at odds with the operational objectives of Supervisory Bodies; this is seen in terms of the value of ‘time’ given by Supervisory Bodies to assess and reflecting the importance of the work in the lives of people. We found that for 74% of BIAs their work is not subject to employer ‘time standards’ in the completion of DoLS assessments. Some BIAs told us that their work continues to be subject only to the statutory timescales for the DoLS. This group asserted strongly that the statutory timescales validate the value and importance of the work. Some told us that whilst they understand the pressures on Supervisory Bodies, they feel strongly that statutory timescales are set within the current DoLS scheme and provide an adequate timeframe for working with complex cases and should not be amended in a bid to increase assessment productively.

Overall the BIA respondents report strong values essential to the core capabilities, with many asserting the importance that their role requires careful, skilled, independent and professional judgements and that sufficient ‘time’ is required to achieve best practice. BIAs understand that the gravity of their decisions can have significant impact upon the people they assess. An analysis of their views suggests strong values consistent with the

promotion of independence, right to autonomy and self-determination and the presumption of capacity. This is also balanced with a concern for best interests, a right to safety and proportionality and in the provision of care and protection. Overall, our narrative findings see BIAs advocating strongly for reasonable assessment timeframes and this correlated strongly with their concerns about the complexity of the work.

We anticipated in making this time study that the course of a DoLS assessment could be easily described in terms of time. Whilst we can produce some simple data to support this, in reality the complexity of the DoLS assessment process means that BIAs and the work they do is subject to a range of multifarious and often competing and conflicting variables that *must* be considered when aiming to measure (in time) what they do.

Reflection

The notion that we can quantify the work of the BIA wholly in 'time' and use it as a template for practice is tantalising in the face of an overwhelming number of outstanding DoLS applications. Nevertheless, in making this study we do not aim to enable local authorities to simply calculate the 'cost' (time and money) of a BIA's work as this has too many variables, as we have discussed.

Firstly, we recognise that BIAs must grapple with the DoLS, a scheme known for its considerable bureaucracy whilst negotiating its intricacies in the face of case law changes and ever shifting legal parameters.

Secondly, DoLS assessments can vary greatly in complexity, however in all cases the BIA must involve the relevant person in the assessment process, consult widely and gather information relevant to their decision-making and provide a report that explains their conclusion and their reasons for it. This work can be time consuming, particularly when there are several consultees or extended travelling times.

Thirdly, BIAs are independent in their decision-making, their assessments may well be subject to the scrutiny of the Court and they must always be prepared to face a legal challenge.

At the time of writing, the future of the DoLS is uncertain. How long legislative change will realistically take is not yet clear. In the meantime, whilst we wait, the good practice of BIAs will continue. It is apparent to us that this study is more than an exercise in measuring 'time', although that is its chief premise. The narrative findings tell us more about BIAs and their work and how time pressures can coalesce to add to the complexity of what they do. Their role is critical to the management of the DoLS; by learning more about the time it takes them to complete their assessments (including any 'time standards' they may have to work within) we have also found out more about the effect of the changes since Cheshire West. To this end, we believe that the BIAs experience of the DoLS in practice is critical if we are to understand the changes that are to come. Their views are of equal standing to those of the doctors, lawyers and socio-political commentators whose observations currently fuel the debate about the future of DoLS. We hope in this discussion to add their voice to the evidence base for practice.

Appendix One

Questions 1 to 18 Data Summaries

Figure 1.0

Question 1 – *"I am a practicing…"*

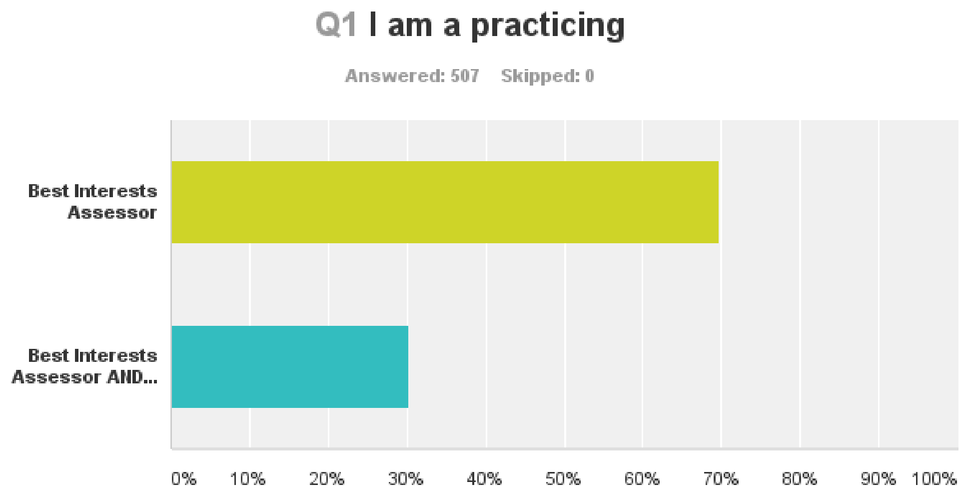


Figure 2.0

Question 2 – *"I am professionally trained in…"*

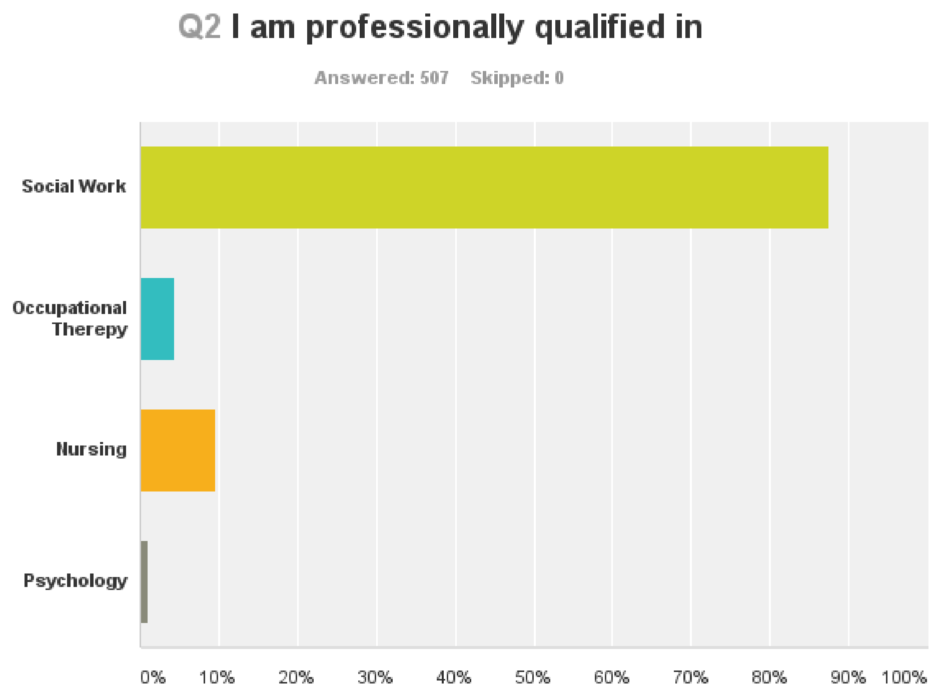


Figure 3.0

Question 3 – *"Who do you work for?"*

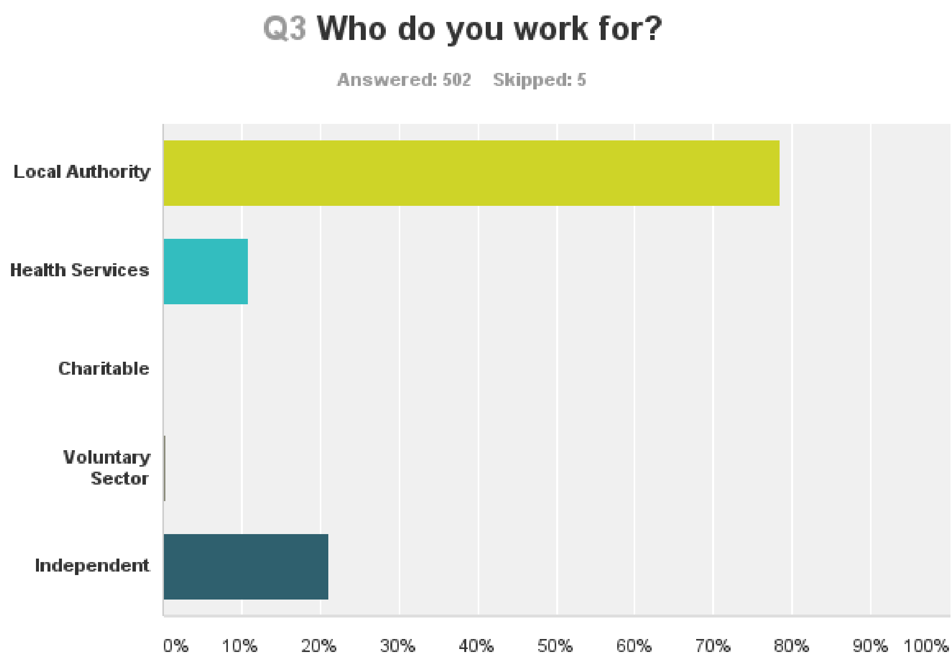


Figure 4.0

Question 4 – *"Consider a recent DOLS assessment you have undertaken. Which requirements were you asked to assess?"*

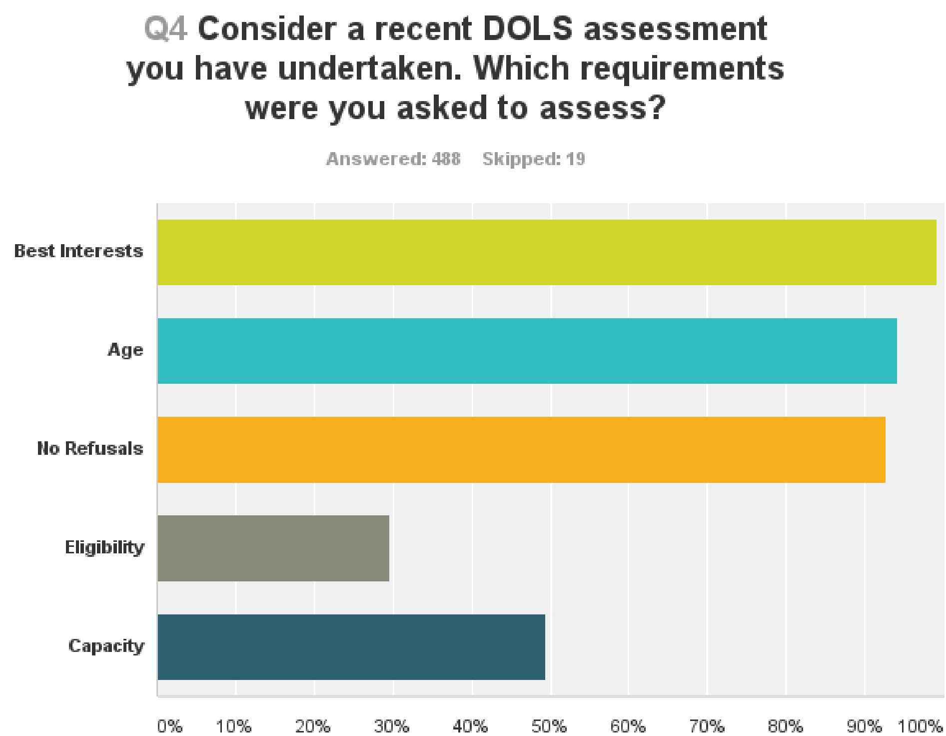


Figure 5.0

Question 5 – *"Was it an initial (or first) authorisation OR a re-assessment for a further period of authorisation?"*

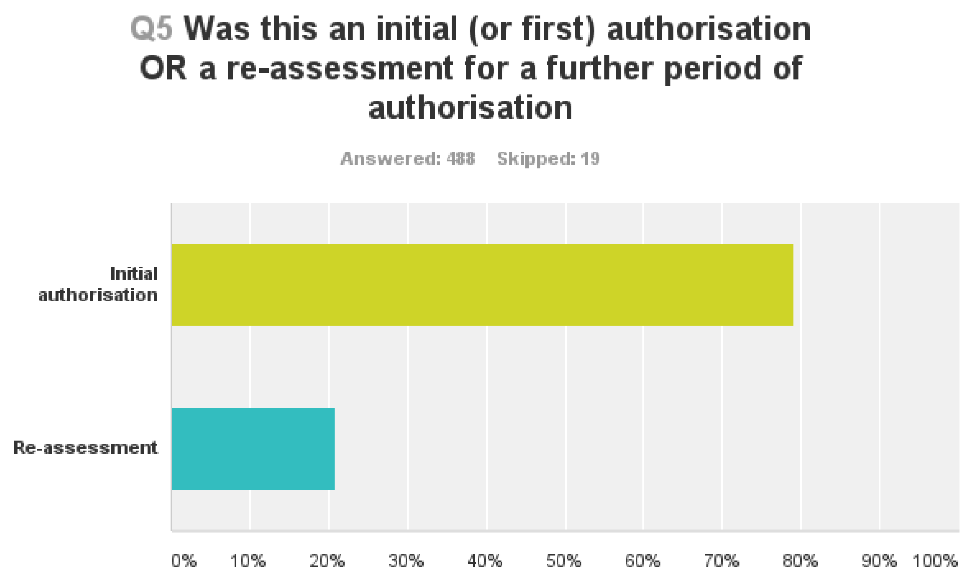


Figure 6.0

Question 6 – *"In your opinion was this assessment 'complex' OR 'reasonably straightforward" (use the ADASS Priority Criteria link above to help with rating if you wish)*

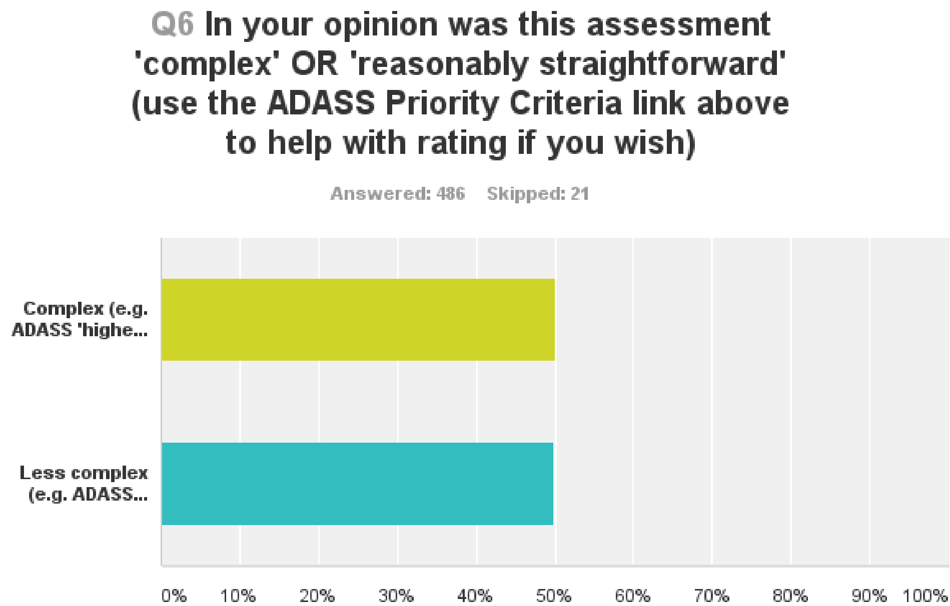


Figure 7.0

Question 7 – *"Approximately how long did it take you to travel?"*

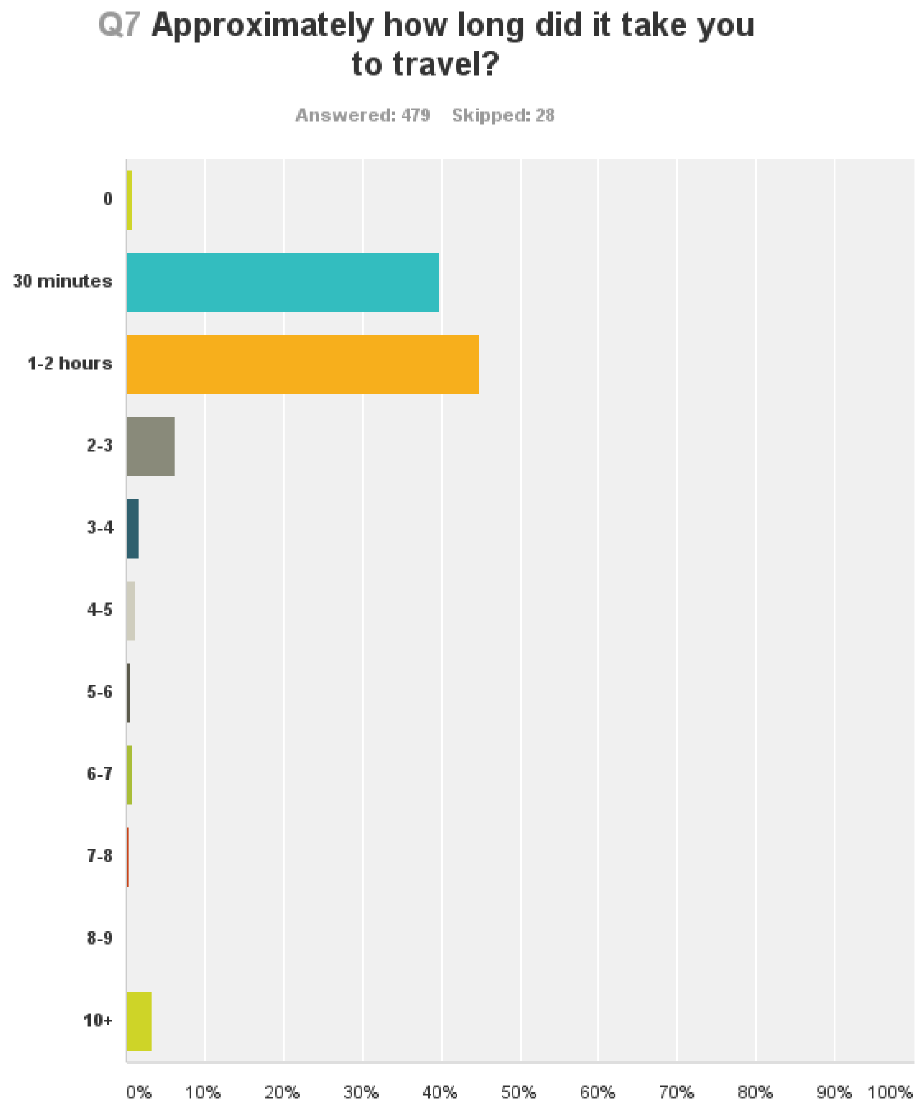


Figure 8.0

Question 8 – *"Prior to your visit approximately how long did you spend gathering information/consulting with others?"*

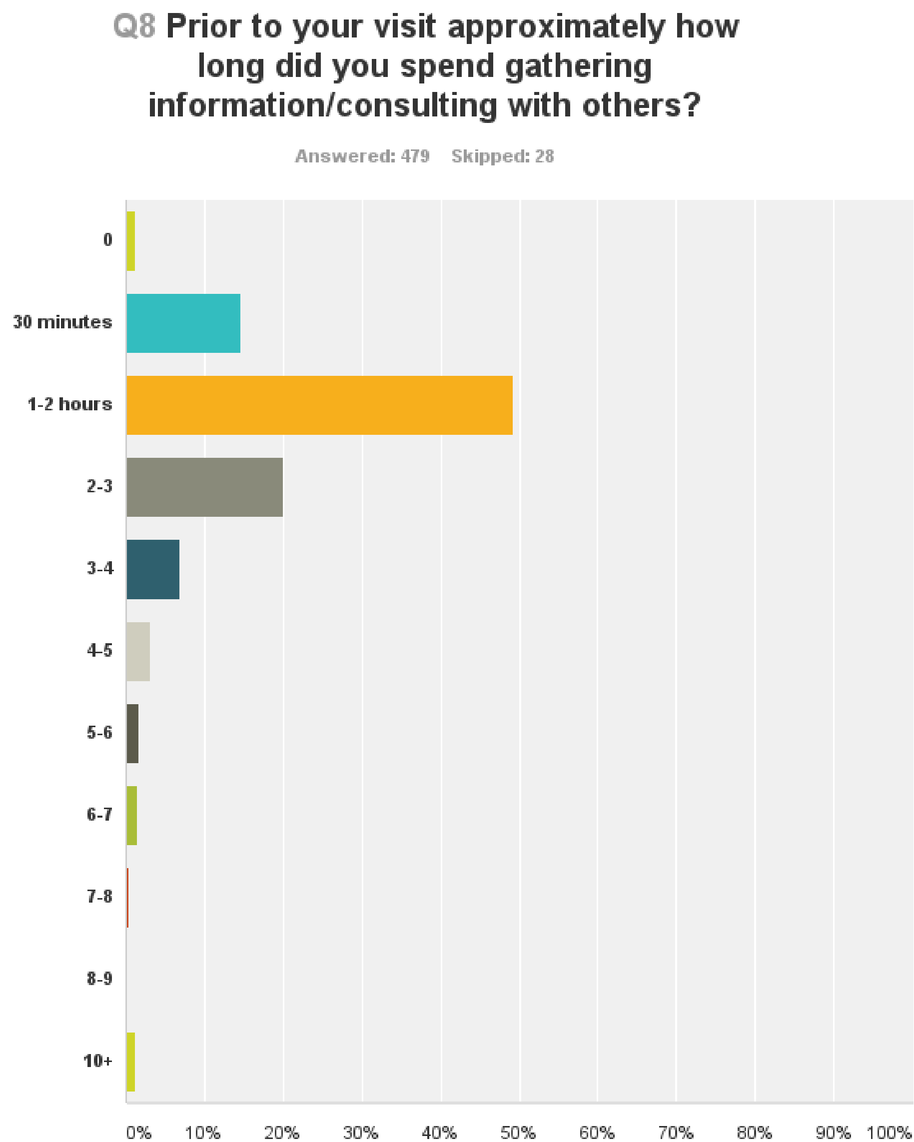


Figure 9.0

Question 9 – *"Approximately how long did you spend at the hospital or care home checking gathering information (e.g. consulting with P and others?"*

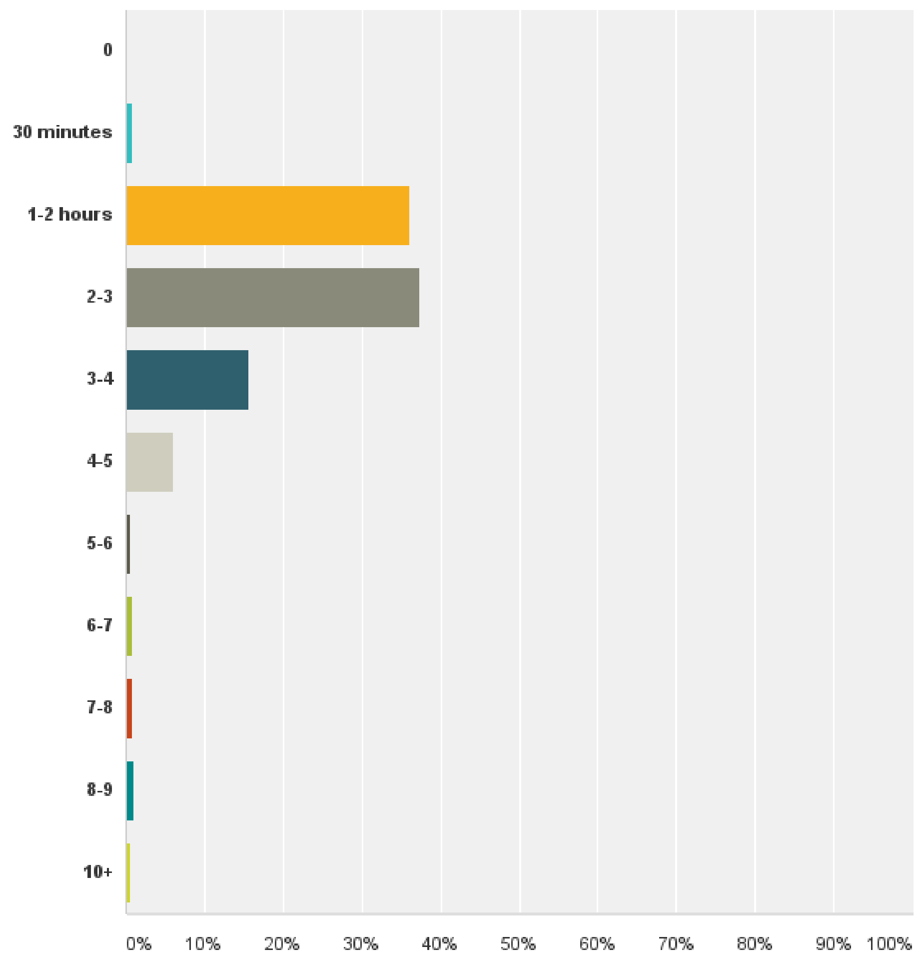


Figure 10.0

Question 10 – *"Approximately, how long did you spend consulting with the mental health, capacity and/or eligibility assessor?"*

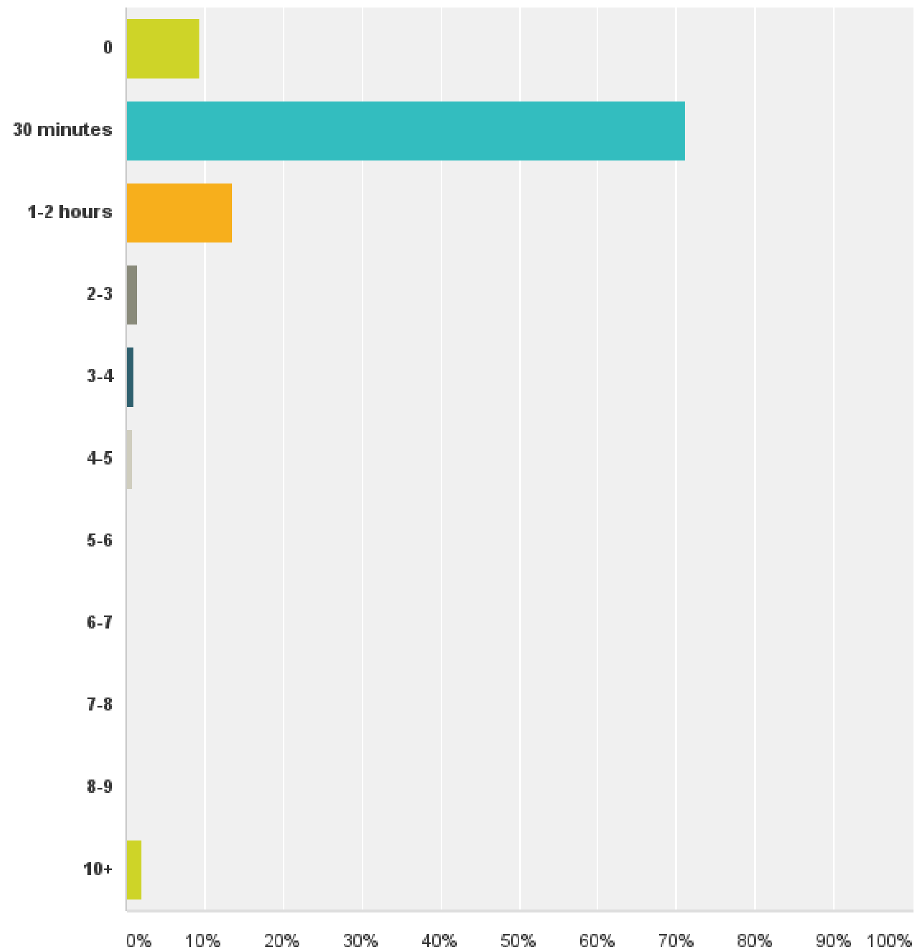


Figure 11.0

Question 11 – *"Approximately, how long did you spend gathering information and consulting with others after your visit to the hospital or care home?"*

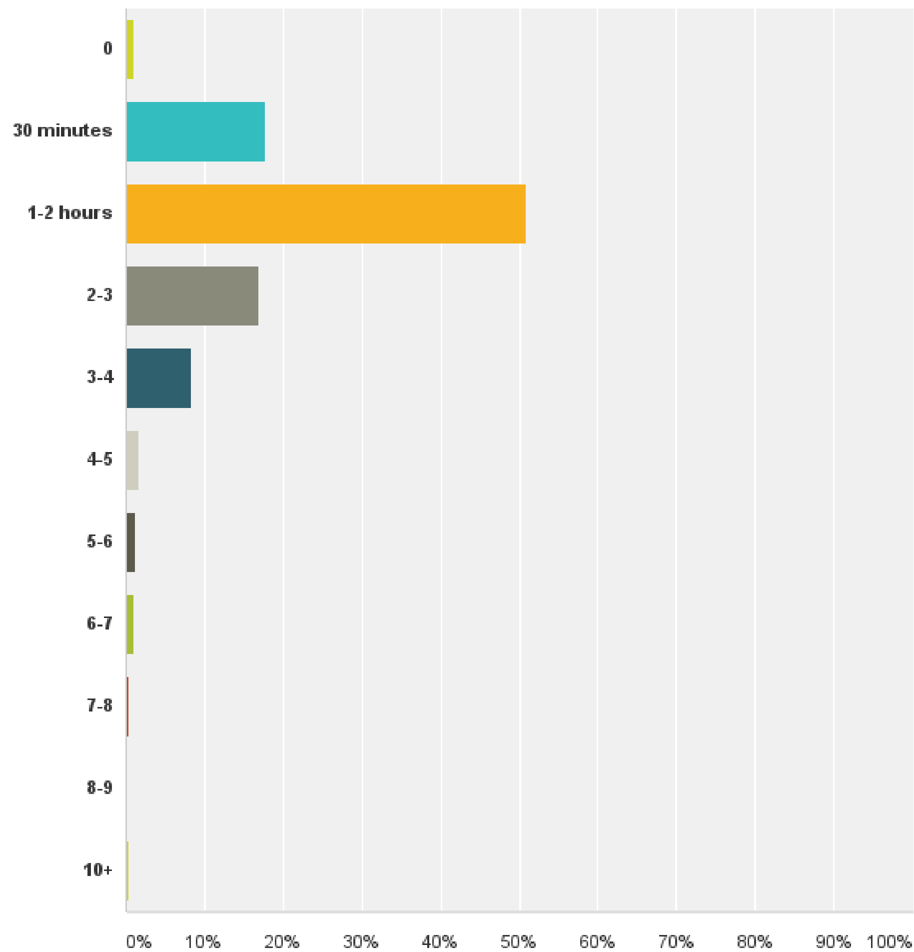


Figure 12.0

Question 12 – *"Approximately, how long did you spend writing up all the documents?"*

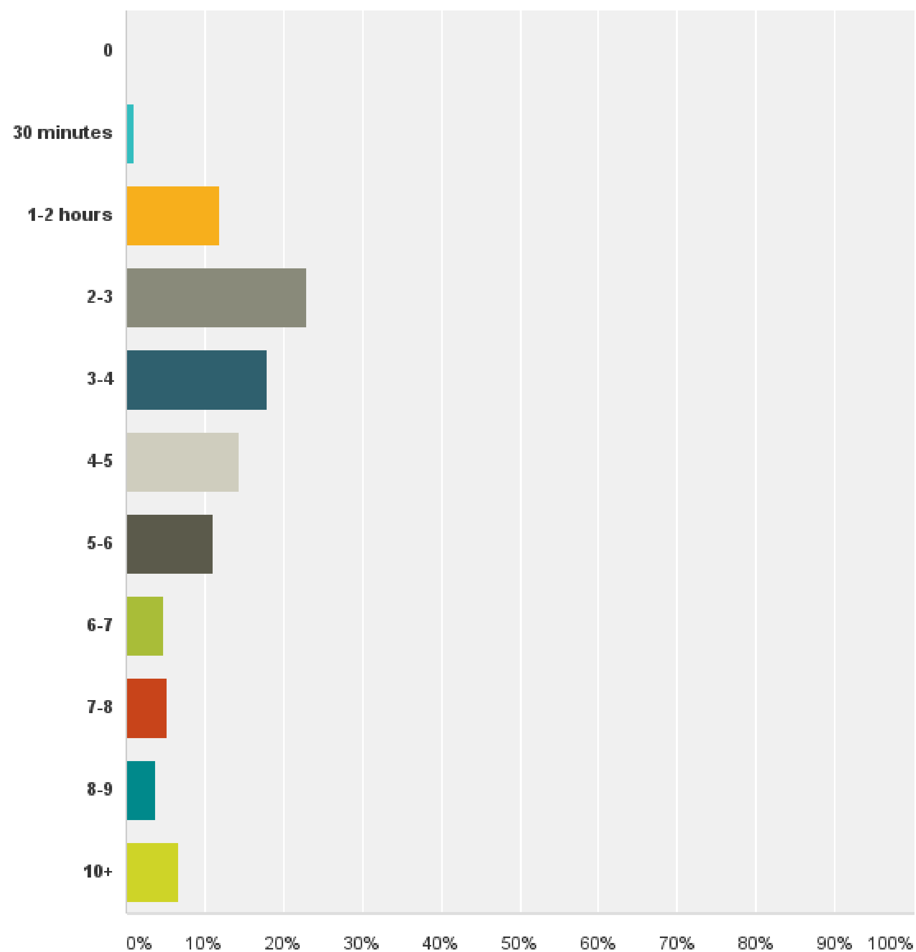


Figure 13.0

Question 13 – *"Approximately, how long did you spend giving feedback to the Managing Authority?"*

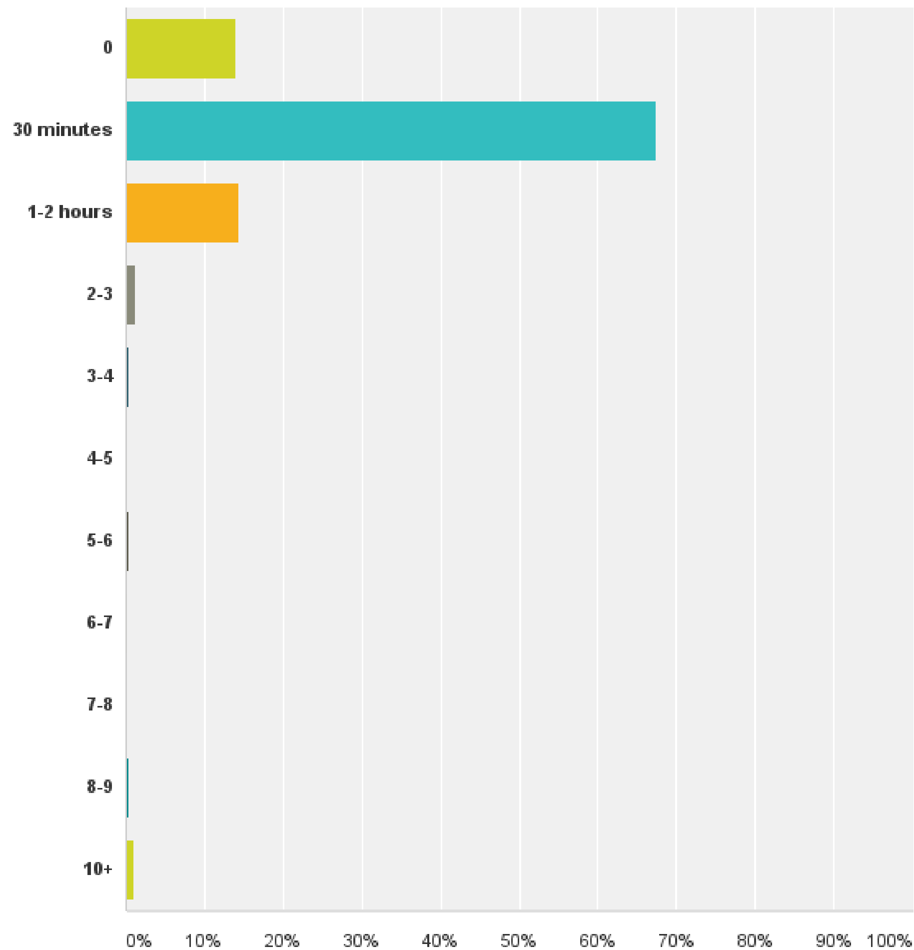


Figure 14.0

Question 14 – *"Approximately, how long did you spend giving feedback to the Supervisory Body, care team or others?"*

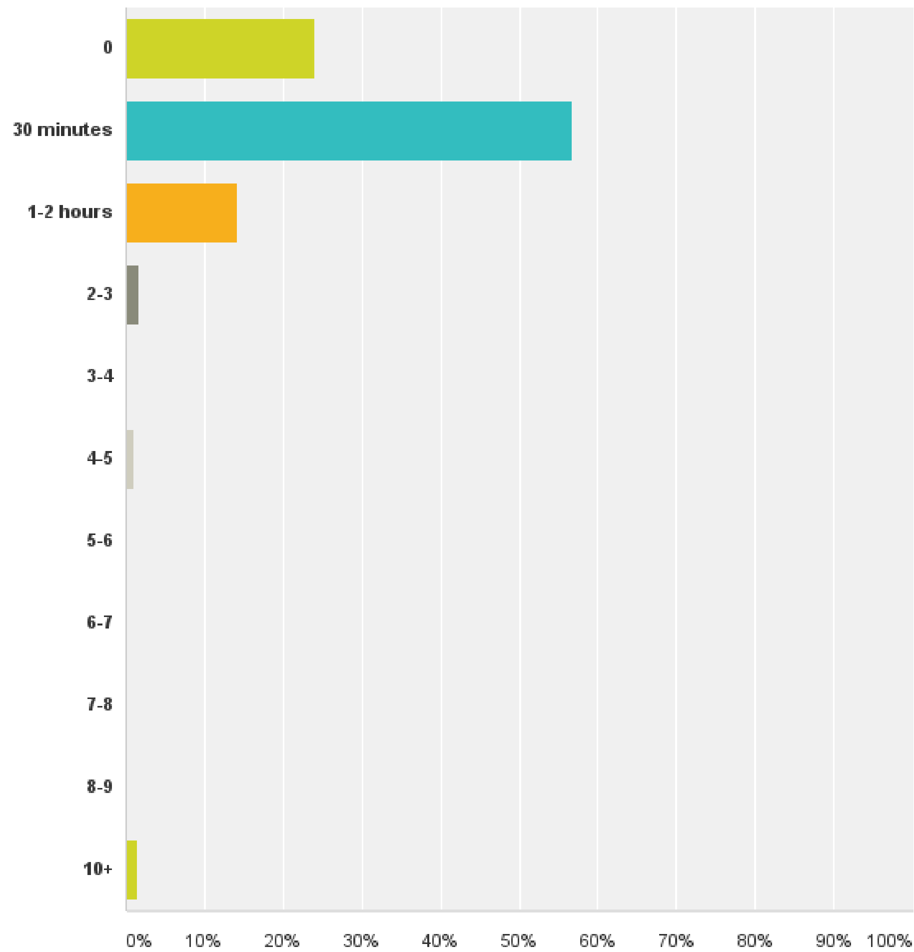


Figure 15.0

Question 15 – *"Did you use the new Association of Directors of Adult Social Services ("ADASS") forms?"*

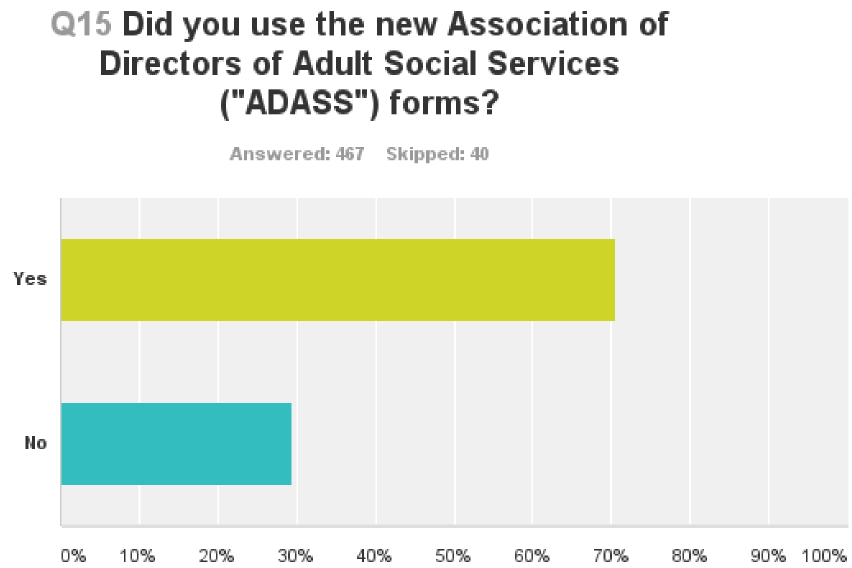


Figure 16.0

Question 16 – *"Are the forms you used part of and electronic records system?"*

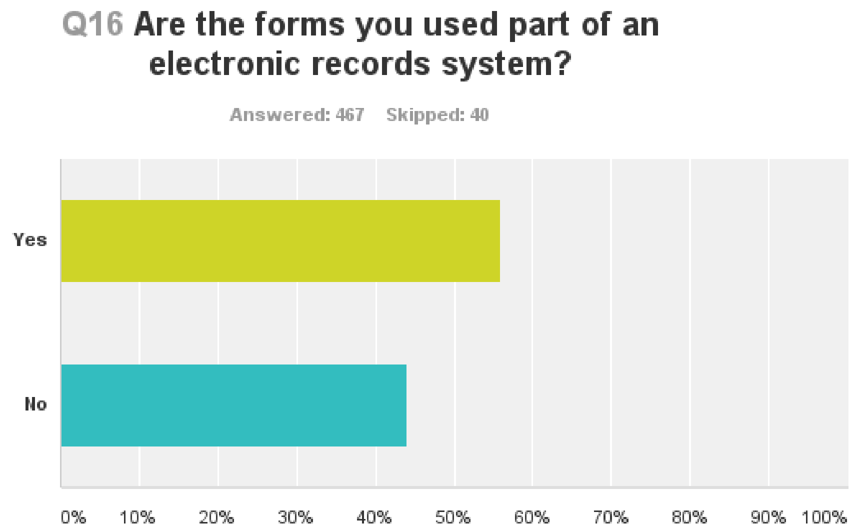


Figure 17.0

Question 17 **–** *"Has your employer set a 'time standard' for the completion of assessments?"*

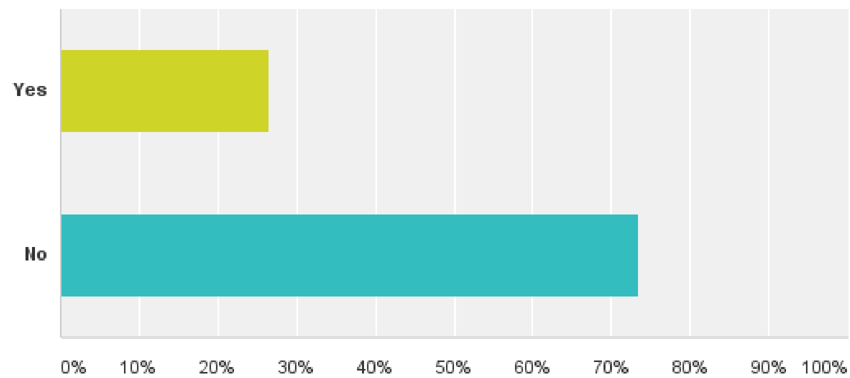
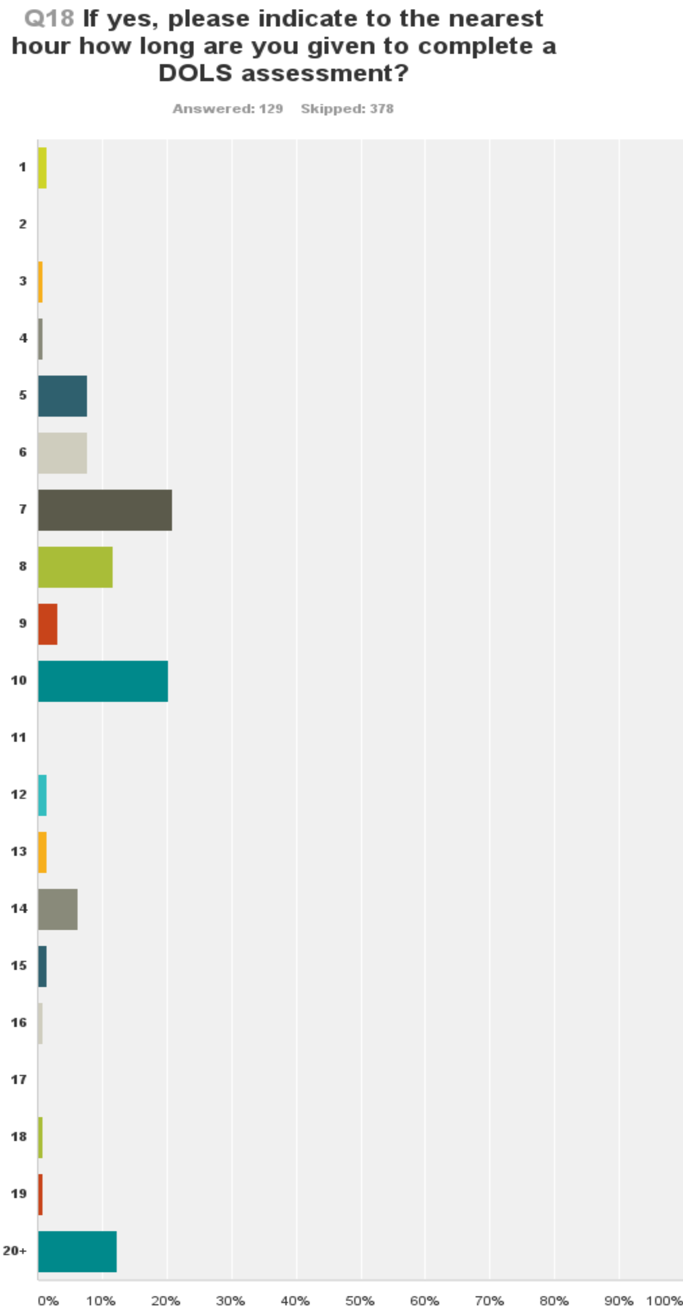


Figure 18.0

Question 18 – *"if yes please indicate to the nearest hour how long you are given to complete a DOLS assessment?"*

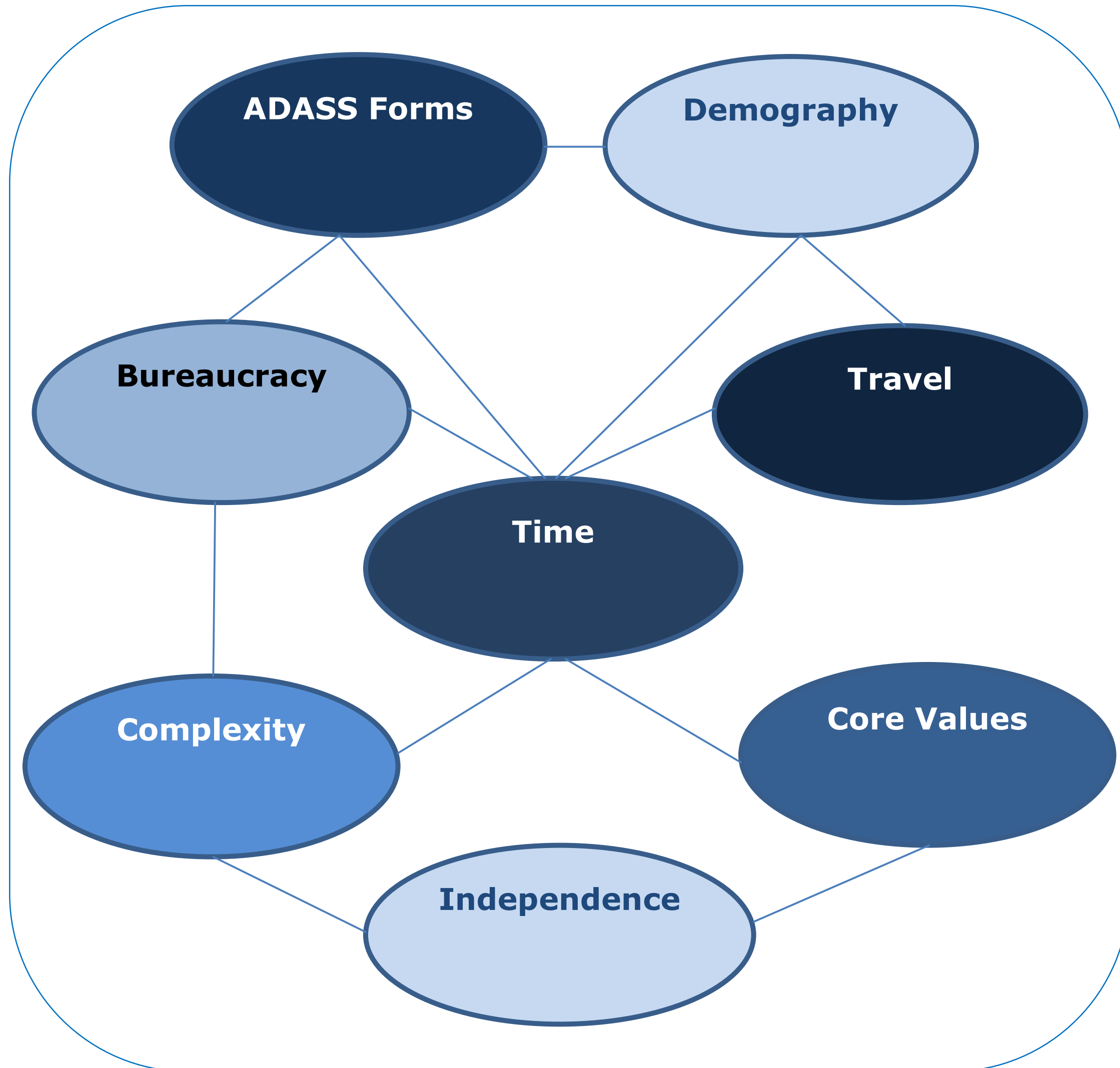


Appendix 2

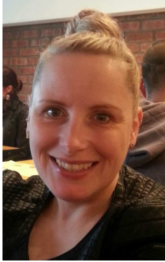
Question 19 – Thematic Map

Figure 19.0 Thematic Map

Question 19 – *"is there anything else you would like to tell us?"*



About the authors



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The DOLS Team - Cornwall

(Some the team)

The DoLS team at Cornwall Council are comprised of dedicated Approved Mental Health Professionals/Best Interests Assessors and Best Interests Assessors. Formed in 2008/2009 we work with children, people with learning disabilities and older adults in respect of our statutory duties under the Mental Health Act (1983) and with people over the age of 18 for DoLS.

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2 December 2015

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