HYWEL DDA UNIVERSITY HEALTH BOARD

Deprivation of Liberty Safeguards Policy

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Brief Summary of Document:	This document helps staff to understand what situations might constitute a deprivation of liberty and outlines the steps to follow in considering and applying for an authorisation under the Deprivation of Liberty Safeguards. It also outlines the responsibilities of the Supervisory Body in responding to applications.
Scope:	The Deprivation of Liberty Safeguards apply to all in inpatient settings within the Health Board, including those managed by Mental Health and Learning Disability services, and all staff have a duty to be aware of the DoLS framework and apply it where necessary
To be read in conjunction with:	Mental Capacity Act 2005 Code of Practice (2007) Mental Capacity Act 2005 Deprivation of liberty safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice (2008) Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards (WAG 2009) Guidance for Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards (WAG 2009),

	018 -Guidance on the Mental Capacity Act 2005 014 - Policy on Advanced decisions Independent Mental Capacity Advocacy Service Policy 141
Patient information:	http://howis.wales.nhs.uk/sitesplus/862/page/71445

Owning Committee/ Group	Mental Capacity and Consent Group

Executive Director:	Joe Teape	Job Title	Deputy Chief Executive

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	16.4.2012
2	Amendments to reflect changes in case law	5.11.2015
3	Full review	30.05.2019
4	Updating policy to reflect national guidance and in response to HIW recommendation Reuploaded 29.1.2021 Reuploaded 17.2.2021 as formatting incorrect	17.12.2020 17.2.2021

Glossary of terms

Term	**Definition**
Assessor	A person who carries out an assessment under the deprivation of liberty safeguards.
Best Interests Assessor	The assessor appointed by the Supervisory Body to undertake the 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.
Care home	A care facility registered under the Care Standards Act 2000.
Conditions	Requirements that a Supervisory Body may impose when giving a standard authorisation.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
Deprivation of liberty	Deprivation of liberty is a term used in the European Convention on Human Rights to describe circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.

Deputy	Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.
Donee	Someone appointed under a Lasting Power of Attorney who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the Lasting Power of Attorney.
Detained resident	A person detained in a hospital or care home – for the purpose of being given care or treatment – in circumstances which amount to a deprivation of the person's liberty.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service.
Section 39A IMCA	An IMCA who is instructed by the Supervisory Body where there is no-one appropriate to consult and the relevant person is: • subject to an urgent authorisation or • an assessment has been requested for a standard authorisation or • a best interest assessor has been appointed to decide whether or not the relevant person is being deprived of their liberty following a request from a third party.
Section 39C IMCA	An IMCA who is instructed by the Supervisory Body where the relevant person is subject to a standard authorisation under DoLS and: • there is no-one appropriate to consult and • there is a gap between when the relevant person's representative involvement ends and the appointment of a replacement representative.
Section 39D IMCA	An IMCA who is instructed by the Supervisory Body where the relevant person is subject to a standard authorisation and a request for IMCA support is made by: • the relevant person • the relevant person's representative • or when the Supervisory Body believes that the relevant person or their representative would be unable, unlikely or has failed to exercise the right to a review or to apply to the court A section 39D IMCA is not available where the relevant person has a paid representative (such as a solicitor).
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 appointing an attorney (donee), or attorneys, to make decisions about the donor's welfare, including healthcare, and/or deal with the donor's property and affairs.
Managing Authority	The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.
Mental Capacity Act 2005	Legislation that governs decision-making for people who lack capacity to make decisions for themselves or who have capacity

	and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.
Mental Health Act 1983	Legislation concerning the care and treatment of patients with mental disorder. It sets out the requirements for detention in hospital for assessment or treatment of mental disorder, supervised community treatment and guardianship.
Qualifying requirement	Any one of 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 person	The person in question (i.e. the patient in a hospital, the resident in a care home).
Relevant person's representative	A person, independent of the hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards. Usually referred to as the RPR
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Standard authorisation	An authorisation given under Part 4 of Schedule A1. It is an authorisation given by a Supervisory Body after completing the assessment process, giving the lawful authority to deprive a relevant person of their liberty in the relevant care home or hospital.
Supervisory Body	A local authority or local health board that is responsible for considering a deprivation of liberty request received from a Managing Authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given under Part 5 of Schedule A1. It is an authorisation given by a Managing Authority, that provides the Managing Authority with 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

Keywords	Deprivation of liberty, DoLS, mental capacity, Deprivation of Liberty Safeguards, Mental Capacity Act.

CONTENTS

1. INTRODUCTION

The Deprivation of Liberty Safeguards are intended to give the protection of proper legal process when deprivation of liberty appears to be unavoidable. They apply to people with a mental disorder (such as people with significant learning disabilities, dementia or impaired cognition as a result of a stroke or mental illness) who lack the capacity to consent to their treatment or care in either a hospital or care home. The Safeguards apply where care or treatment is needed in the person's best interests but it can only be provided in a way that amounts to depriving them of their liberty.

A person may only be deprived of their liberty:

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

The Deprivation of Liberty Safeguards (DoLS) are provisions that have been added to the Mental Capacity Act 2005 (MCA). These safeguards do not apply to people who are below the age of 18 or those who are, or could be, detained under the Mental Health Act 1983.

The Health Board's Deprivation of Liberty Safeguards page can be accessed here for information for staff, patient leaflets and DoLS forms:
http://howis.wales.nhs.uk/sitesplus/862/page/68864

The main Mental Capacity Act 2005 Code of Practice is supplemented by the Deprivation of Liberty Safeguards Code of Practice. This is available via the Health Board's Mental Capacity Act webpage - http://www.wales.nhs.uk/sitesplus/862/page/47577.

There is also Welsh Government guidance for managing authorities which is available here: http://www.wales.nhs.uk/sites3/Documents/744/Guidance%20for%20Managing%20Authorities.pdf and for supervisory bodies which can be accessed here: http://www.wales.nhs.uk/sites3/Documents/744/Guidance%20for%20Supervisory%20Bodies.pdf

2. POLICY STATEMENT

The Health Board is committed to upholding the human rights of its patients and aims to ensure that where necessary care and treatment of an individual in hospital amounts to a deprivation of the individual's liberty appropriate authorisation is sought through the Deprivation of Liberty safeguards.

3. SCOPE

All staff have a duty to be aware of the Deprivation of Liberty Safeguards Framework and apply it where necessary.

4. AIMS

The aim of the policy is to ensure that all patients who need the protection of the DoLS can be identified and referred, and their assessment undertaken, in a timely manner concordant with the assessed level of risk to their human rights.

5. OBJECTIVES

The aim of the policy will be achieved by:

- Explaining the meaning of deprivation of liberty

- Outlining the necessary processes which clinical staff need to follow in deciding whether to submit an application and in making an application under the Safeguards Framework
- Outlining the assessment process under the legislation when an application is made
- Explaining the responsibilities of clinical staff caring for a patient who is subject to a standard authorisation

6. HOW DO THE SAFEGUARDS WORK?

A **Managing Authority** (a hospital or care home) has responsibility for applying to the relevant Supervisory Body for authorisation of a deprivation of liberty for any person who may come within the scope of the Deprivation of Liberty Safeguards. This person may also be referred to as the 'relevant person'*. In the case of an NHS hospital, the Managing Authority is the part of the Health Board responsible for the running of the hospital in which the relevant person is, or is to be, a resident.

If a health or social care professional thinks that a patient might be being cared for in circumstances that could amount to a deprivation of their liberty an authorisation is needed and the Managing Authority must be informed (see 6.1). This might be as a result of a care review or needs assessment but could happen at any other time. There are two types of authorisation under the Safeguards. A Standard Authorisation can be granted where independent statutory assessments confirm the patient and their circumstances meets the necessary criteria and the deprivation of their liberty is necessary in their best interests (see section 6). In situations where it is felt that the person is already being cared for in circumstances which likely amount to a deprivation of their liberty (or a deprivation of their liberty will occur before statutory assessments can be completed) the Managing Authority can issue itself with an Urgent Authorisation to provide lawful authority for their actions (see section 7).

Whilst a patient is being cared for under a Deprivation of Liberty Authorisation, the Managing Authority is responsible for giving the patient information about the authorisation, and his or her rights. It is also responsible for monitoring the involvement of the person who the Supervisory Body appoint to be the relevant person's representative (see Glossary), and monitoring any need for a review of the authorisation.

A **Supervisory Body** is the part of the Health Board responsible for considering requests for authorisations, commissioning the required assessments and, where all the assessments agree, authorising the deprivation of liberty.

Whilst a patient is being cared for under a deprivation of liberty authorisation, the Supervisory Body is responsible for appointing a representative for the patient, instructing an advocate (when appropriate) to support the patient and / or the representative, and arranging reviews of the authorisation.

Regulation 3 of the Representative Regulations sets out the supervisory functions of Local Health Boards (LHBs) in respect of hospitals (NHS or independent), and this needs to be read in conjunction with paragraph 180 and 181 of Schedule A1. In essence, this means the Supervisory Body function is also carried out by the Local Health Board responsible for the hospital where the relevant person is (or is to be) situated accommodated.

* In this policy the terms 'patient' and 'relevant person' have been used interchangeably and should been read as having the same meaning.

Hywel Dda University Health Board is both a Managing Authority and a Supervisory Body and there is potential for a conflict of interests and there should be a clear separation of the different functions within the management structures of the organisation. It is important that staff responsible for carrying out the function of the Supervisory Body should operate entirely independently of staff responsible for managing the hospital and they should not be accountable to the same senior manager or operate from within the same budget. These requirements are reflected in the agreed structure for the implementation of the Mental Capacity Act within Hywel Dda University Health Board.

6.1. What is deprivation of liberty?

Whilst there is no statutory definition, the issue of what amounts to a deprivation of liberty was considered by the UK Supreme Court in its ruling on the *Cheshire West* and *P & Q* appeal cases (UKSC 19 [2014]). The Court outlined an 'acid test' to apply in determining whether a person's circumstances amount to a deprivation of their liberty. A person will be deprived of their liberty if:

- they **lack decision-making capacity** to consent to the current arrangements in relation to their accommodation for care and treatment and
- are **subject to continuous supervision and control** and
- are **not free to leave**

6.2. Explaining the 'acid test'

6.2.1. Lacks decision-making capacity

A person's capacity to consent to their accommodation for care and treatment is determined by applying the two-stage test outlined in the Mental Capacity Act. In short, there must be reasons to doubt the person's ability to make the decision (at the time it needs to be made); there must be evidence of an 'impairment of, or a disturbance in the functioning of the mind or brain' (Mental Capacity Act s.2(1)) causing the person to be unable to either understand, retain, use or weigh the relevant information or communicate a decision (s.3(1), see Mental Capacity Act 2005 Policy No: 374 for further details).

Capacity cannot be based on a person's apparent *happiness* or *compliance* with their care arrangements. Where a person has capacity, their consent provides the necessary lawful authority for their care and treatment but if the person lacks capacity their apparent agreement cannot provide that authority. In these circumstances an alternative source of authority is required, for example, an authorisation under DoLS or the consent of someone with a relevant Lasting Power of Attorney.

6.2.2. Continuous supervision and control

In considering what is meant by 'continuous supervision and control' firstly, it is important to recognise that 'continuous' is not the same as 'constant'. Measures which are 'continuous' are ongoing but they may be intermittent. Guidance from the Law Society https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/ (2015) suggests that 'continuous supervision and control is likely to be present where there is "a plan in place which means that they [*staff*] need always broadly to know:

- where the individual is; and
- what they are doing at any one time"

The purpose of staff needing to be aware of where the person is, and what they are doing may be based on the need to provide necessary care to a vulnerable person, rather than designed to exercise 'staff control'. The Supreme Court (2014) ruled that the purpose of measures is not relevant to the consideration of whether they amount to a deprivation of liberty. This means that where a hospital patient is regularly observed or has regular contact with staff - because of their care needs - then it is likely this would be 'continuous supervision and control'.

6.2.3. Not free to leave

It is important not to view freedom to leave in terms of the person's ability, desire or actual attempts to leave. In other words a person can be 'not free to leave' even if they have shown no desire or inclination to leave the place in which they are confined.

The Law Society suggests that "the focus should be upon the actions (or potential actions) of [*staff*]... rather than the individual themselves" (para. 3.14). Staff must ask themselves this question:

> '*If* the person were to try to leave (or a family member indicated a desire to help them leave) how would I respond?'

If the answer is that steps would be taken to prevent them from leaving, then the person should usually be considered as 'not free to leave'.

There is a difference between the freedom to 'come and go' and the decision of a person to discharge themselves from hospital. Being unable to 'come and go' is, as a minimum, a restriction on a person's liberty which *may* amount to a deprivation of liberty, depending on other factors. Patients who are not able to discharge themselves from the hospital are definitely 'not free to leave'.

6.3. What is the purpose of the Deprivation of Liberty Safeguards?

The Safeguards were devised to provide a proper legal process and suitable protection for vulnerable people who lack the mental capacity to consent to their care arrangements, when deprivation of liberty appears to be unavoidable..

6.4. What situations must the Safeguards not be used for?

Deprivation of liberty must never be used as punishment for the person or for the convenience of staff.

6.5. When should an application be made?

Where the circumstances of a person's care in hospital appear to meet the 'acid test' for a deprivation of liberty (see paragraphs 2.2.1 - 2.2.3 above) this situation will be unlawful unless it is authorised by 'a procedure prescribed by law' (Article 5(1) of the European Convention on Human Rights, 1950). This means that if staff believe a patient's care arrangements meet the 'acid test' then they must submit an application under the Deprivation of Liberty Safeguards; the only exceptions being where authorisation of the deprivation of liberty is sought through detention under the Mental Health Act (1983) or by an application to the Court of Protection.

7. SPECIFIC STEPS WHEN CONSIDERING WHETHER TO APPLY FOR AUTHORISATION OF A DEPRIVATION OF LIBERTY

7.1. Is the person over 18 years of age?

The Deprivation of Liberty Safeguards only apply to persons over the age of 18. For young people less than 18 years old consider the use of the Children Act 1989 or if, the young person requires mental health treatment, consider the Mental Health Act 1983.

7.2. **Does the person lack capacity to consent to the arrangements for their care and treatment in hospital?**

Staff must have a reasonable belief that the person lacks capacity to make this decision (see also paragraph 2.2.1 of this policy and the Mental Capacity Act 2005 Policy No: 374). If the person has capacity then an application cannot be made.

As long as staff have a reasonable belief that the person will likely lack capacity to make this decision then an application can be made. If there is considerable doubt about whether or not the person has capacity to give a valid consent to their care and treatment in hospital then undertaking a formal capacity assessment will be helpful in establishing whether or not a DoLS application is required.

7.3. **Does the person have a mental disorder?**

These safeguards only apply to people with a mental disorder such as a significant learning disability, dementia or mental illness. A mental disorder is defined in law as “any disorder or disability of the mind” (s.1 (2), Mental Health Act 1983). Staff need to be aware that a mental disorder can also be caused by medical problems, for example, delirium.

7.4 Is, or could, the person be detained under the Mental Health Act 1983 (MHA)?

The interface between the Mental Health Act and DoLS is acknowledged to be especially complex. Nevertheless, staff must consider whether the person's circumstances may be more appropriately authorised through use of the Mental Health Act. In trying to decide whether a DoLS application or a Mental Health Act assessment is more appropriate consider the following guidance table:

Situation	DoLs ***may*** be appropriate	Mental Health Act ***may*** be appropriate
The person is in hospital to receive treatment for a mental disorder	The person lacks capacity and does not appear to object to being in hospital or receiving treatment for their mental disorder	The person is objecting to being in hospital and/or the treatment for their mental disorder
The person is in hospital receiving treatment for both a mental disorder and an (unrelated) physical illness	The person lacks capacity and the treatment of the physical illness is considered the primary reason why the person needs to be in hospital	The treatment of the mental disorder is considered to be the primary reason why the person needs to be in hospital
The person is in hospital being treated for a physical illness (e.g. an infection) which causes a mental disorder (e.g. delirium)	The person lacks capacity and the symptoms of their mental disorder can be reasonably managed in a general health setting	The symptoms of their mental disorder (e.g. severe behavioural disturbance) cannot be reasonably managed in a general health setting and pose a risk of harm to the person and/or others

These examples are only for illustration. If staff are unclear about whether a DoLS application or a Mental Health Act detention is the more appropriate, seek advice from:

- The MCA Senior Practitioner or your hospital's MCA Practitioner
- The DoLS Coordinator
- The Mental Health Act Department
- Mental health liaison professionals

Regarding the interface between the two Acts, the MHA Code of Practice for Wales (13.45) states:

Hospitals should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the Mental Health Act or DoLS should be used to give legal authorisation to a deprivation of liberty. A clear decision making process should be described including how to access appropriate legal advice if required.

To meet this requirement HDUHB will facilitate the formation of an ad hoc MHA/MCA interface advisory group. This should comprise of representatives from MHA and MCA/DoLS services, IMCA and IMHA services, AMHPs, legal services and the MHA Administration Team. The aim of the group will be to guide consistent and legally coherent decision making, based on

consideration of legislation, existing and evolving case law and UK or Welsh Government guidance.

The emphasis should be on preventing issues arising rather than resolving issues that have already occurred. Clear decision making on which Act to use will minimise the risk that patients become subject to multiple assessments under the MHA and MCA/DoLS, or of there being an unauthorised deprivation of their liberty. To achieve this aim with individual patients, where the possibility exists of it being unclear which Act to use, early communication between Mental Health and DoLS services will be essential.

For patients who are already admitted, or being considered for admission, to mental health inpatient units the referral process flow chart in **Appendix A** should be followed. Eligibility will be considered prior to a formal DoLS referral being made through discussion between Mental Health and DoLS services.

For all other DoLS referrals the usual process set out at 8.2 of this policy should be followed: How to make a DoLS referral . Eligibility will be assessed during the DoLS assessment process. The DoLS Coordinator will ensure that consultation with Mental Health services is undertaken at the earliest opportunity should a complex Eligibility issue be subsequently identified.

The following principles should be noted by decision makers under the MHA and MCA/DoLS when determining which Act to use:

- The Supervisory Body of HDUHB is responsible for determining whether a patient meets the Eligibility requirement for DoLS, and therefore whether a DoLS Standard Authorisation can be given. Their decision will be based on its acceptance of the outcome of the Eligibility assessment where undertaken. Consultation as described above will help ensure that a consensus has been reached wherever possible.

- It will be assumed that the MHA and MCA/DoLS hold equal weight and neither has primacy over the other.

- It is not required to decide (or even consider) whether an application under the MHA would be in the person's best interest (DoLS Code of Practise 4.49).

- If a patient is objecting to being admitted to hospital, or to some or all of the treatment they will receive there, for mental disorder then only the MHA is available to authorise their detention (subject to all other qualifying requirements). (MHA Code of Practice for Wales 13.33).

- Guidance on what constitutes objection can be found in the MHA and DoLS Codes of Practice, but in deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting (MHA Code of Practice for Wales 13.38).

- If, despite the above process being followed, the outcome of the Eligibility assessment is disputed, or where there is a risk of an unauthorised deprivation of the person's liberty occurring because neither detention under the MHA nor MCA/DoLS has been agreed, the matter must be urgently referred for legal advice and guidance on how to proceed *(insert contact details here*).

7.5 Would a DoLS authorisation conflict with another existing form of decision making authority for the person?

The Safeguards cannot be used to authorise measures with the purpose of giving treatment, if the patient has made a valid and applicable advance decision to refuse that treatment.

Similarly, if any element of the care plan (which may deprive the person of their liberty) would be in conflict with a decision made by a deputy appointed by the Court of Protection (see Glossary, 'Deputy') or an attorney appointed by the person (see Glossary, 'Lasting Power of Attorney') acting within the scope of their authority, then the authorisation cannot be given. In such situations seek advice from the Senior MCA Practitioner or your hospital's MCA Practitioner.

7.6 Are there less restrictive alternatives to the proposed care?

If there are less restrictive alternatives available these should be implemented without delay and the care plan amended to reflect this. Since the Supreme Court judgment of 2014 it is less likely that reducing restrictions on a vulnerable patient will serve to negate the need to make a DoLS application but minimising necessary restrictions remains important to consider so that our care of patients who lack capacity is in line with the 'least restrictive' principle of the MCA.

8 APPLICATION FOR A STANDARD AUTHORISATION OF A DEPRIVATION OF LIBERTY

(DoLS Code of Practice, chapter 3 and Welsh Govt. Guidance for Managing Authorities, pages 8-11)

Managing authorities should have a procedure in place that identifies:

- whether deprivation of liberty is or may be necessary in a particular case
- what steps they should take to assess whether to seek authorisation
- whether they have taken all practical and reasonable steps to avoid a deprivation of liberty (see paragraph 5.6 above)
- what action they should take if they do need to request an authorisation
- how they should review cases where authorisation is or may be necessary, and who should take the necessary action.

An application for a standard authorisation must be made where it is anticipated that a person's future care will meet the 'acid test' for a deprivation of liberty. If the person's current care meets the 'acid test' then an application for a Standard Authorisation must be used *in conjunction* with issuing an Urgent Authorisation (see paragraph 9 below).

8.4 Individual staff responsibility

If a member of staff feels a person in their care is, or will be deprived of their liberty, they must raise this concern with the Ward Manger or shift leader. Where a DoLS application has been made individual staff are responsible for cooperating with the statutory assessors appointed by the Supervisory Body to enable them to carry out the necessary assessments.

8.5 Responsibilities of the healthcare professional most closely involved with the patient's care

In many instances the healthcare professional most closely involved in the patient's care will be the registered nurse currently looking after the patient. In some cases other professionals may be more closely involved and better placed to undertake these responsibilities; for example, an Occupational Therapist may be more closely involved in the care of a patient who is recovering from a stroke.

The healthcare professional most closely involved is responsible for:

- deciding whether or not the patient's care arrangements meet the 'acid test' for deprivation of liberty and for completing a DoLS application.
- ensuring Form 1 is emailed to the Health Board's DoLS office: dols.hdd@wales.nhs.uk
- ensuring that the person's family, friends, carers (and any involved Independent Mental Capacity Advocate) are informed of the application and...
- providing them with appropriate information about the process. Patient and carer information leaflets about the Mental Capacity Act and the Deprivation of Liberty Safeguards are available on the Health Board's DoLS intranet page - http://howis.wales.nhs.uk/sitesplus/862/page/68864ensuring that once an application has been made this is clearly recorded in the clinical records and communicated with the ward based team

8.6 Administrative responsibility

The Deprivation of Liberty Safeguards Coordinator (or nominated person) is responsible for confirming with the relevant ward that the application has been received and requesting any further information that is required and not apparent on the application.

8.7 Relevant Person's Representative (RPR)
(DoLS Code of Practice, chapter 7 and Welsh Govt. Guidance for Managing Authorities, pages 21-22)

The Safeguards aim to ensure that the relevant person (the person subject to a DoLS application/authorisation) has an active representative throughout the period of the authorisation. The Supervisory Body will appoint a representative to support the relevant person. The representative is an important safeguard for the relevant person. The Supervisory Body needs to be satisfied that the person they appoint as the RPR is willing and able to:

- "maintain contact with the relevant person
- represent and support the relevant person in all matters relating to the deprivation of liberty... , including, if appropriate, triggering a review, using the... [Health Board's] complaints procedure on the person's behalf or making an application to the Court of Protection" (DoLS Code of Practice, para. 7.2)

The RPR has a legal responsibility to trigger a review of the authorisation, and to consider an application to the Court of Protection where they are unhappy, or the relevant person is indicating they are unhappy with the requirement to remain in hospital. The Supervisory Body is responsible for terminating the appointment of representatives in certain situations (such as where the representative is not maintaining contact with the patient or failing to ensure their rights are protected), and appointing a new representative as soon as possible.

The Managing Authority is under a duty to inform the Supervisory Body if the representative appears not to be maintaining sufficient contact with, or acting in the best interests of, the relevant person.

If the appointment of a representative has been terminated, and in cases where there is no one (unpaid) who may be consulted, the Managing Authority is under a duty to notify the Supervisory Body of the issue. The Supervisory Body must then appoint an IMCA (see below) to represent the person, until such time as a new representative can be appointed; this is known as a '39C IMCA'.

8.8 Independent Mental Capacity Advocate (IMCA)
(DoLS Code of Practice, chapter 7 and Welsh Govt. Guidance for Managing Authorities, pages 23-24)

Patients who are unbefriended are entitled to advocacy support during the assessment process. When making an application for an authorisation, the Managing Authority has a duty to inform the Supervisory Body if there is nobody appropriate for the Best Interests Assessor (see Glossary 'Best Interests Assessor') to consult, other than professionals or paid carers. The Supervisory Body will then instruct an IMCA to support and represent the person through the assessment process; this is known as a '39A IMCA'.

If a deprivation of liberty is authorised, both the person who is deprived of their liberty under a standard authorisation and their representative are entitled to receive support from the IMCA service, unless the relevant person has a paid 'professional' representative. The Managing Authority has a duty to give information both to the patient and to the representative about the entitlement to request support from the IMCA service, and how to make such a request.

This issue should be regularly reviewed with the relevant person and their representative throughout the duration of an authorised deprivation of liberty. When there is such a request, the Supervisory Body will instruct an IMCA.

The Supervisory Body will also instruct an IMCA if it is believed that, without an IMCA, the person or their representative would be unable to exercise their right to apply to the court or to request a review of the authorisation; or if it is believed that the relevant person or their representative would be unlikely to exercise this right when it would be reasonable to do so; this is known as a '39D IMCA'.

8.9 Reviews
(DoLS Code of Practice, chapter 8 and Welsh Govt. Guidance for Managing Authorities, page 19)

Where it appears that the relevant person no longer meets the qualifying requirements for being deprived of their liberty the Managing Authority is under a duty to ask the Supervisory Body for a review. The Supervisory Body must undertake a review when it receives such a request, and must also carry out a review if requested by the relevant person or their representative (who may also make an application to the Court of Protection).

9 URGENT AUTHORISATION TO DEPRIVE SOMEONE OF THEIR LIBERTY
(DoLS Code of Practice and Welsh Govt. Guidance for Managing Authorities, pages 15-18)

If possible, an application should be made before a deprivation of liberty occurs. However if this is not possible, an Urgent Authorisation may be given to itself by the Managing Authority, to make the deprivation of liberty lawful for 7 days.

If the Managing Authority considers that the person's current care arrangements amount to a deprivation of liberty an Urgent Authorisation must be issued (in conjunction with an application for a Standard Authorisation). Carers and family members must be informed as early as possible that an Urgent Authorisation has been issued. Ward based professionals must record the steps taken to inform family, friends or carers in the person's records.

The decision-maker from the Managing Authority will need to be able to show that they have made a reasonable decision based on careful consideration of the 'acid test' for a

deprivation of liberty (see paragraph 2.2 above).

9.4 Timescales for Urgent Authorisation
(Welsh Govt. Guidance for Managing Authorities pages 13, 15 & 16)

The Urgent Authorisation cannot authorise a deprivation of liberty for longer than 7 days. The Managing Authority cannot extend the period of urgent authorisation itself. However, the Managing Authority may make one request to the Supervisory Body to extend the period of Urgent Authorisation if a standard authorisation has not yet been processed. If granted, this extension can be for no longer than 7 days. The person, their family, friends, carers and any involved IMCA must be kept informed.

Because the need for an extension of an Urgent Authorisation can only arise where the Supervisory Body is unable to complete the assessment process within the required timescales, in this Health Board the Supervisory Body will actively initiate an extension where they deem it appropriate by contacting the relevant ward and asking them to complete the request form.

The Managing Authority must keep a copy of any Urgent Authorisations issued in the patient's record. They must give a copy of the authorisation to the relevant person and any involved IMCA, and place a copy in the relevant person's records. The Managing Authority must also seek to ensure that, as far as possible, the relevant person understands the effect of the authorisation and the right to challenge the authorisation via the Court of Protection. Appropriate information must be given in ways that the relevant person is more likely to understand.

The Managing Authority should, as far as possible and appropriate, notify the relevant person's family, friends and carers when an Urgent Authorisation is given in order to enable them to offer informed support to the person.

10 THE OUTCOME OF THE APPLICATION
(DoLS Code of Practice chapter 5)

The Managing Authority is responsible for ensuring that it does not deprive a person of their liberty without an authorisation. The Managing Authority must comply with the law in this respect; where a request for a Standard Authorisation is turned down, it will need to review the relevant person's actual or proposed care arrangements to ensure that a deprivation of liberty is not allowed to either continue or commence.

The actions that the Managing Authority should consider if a request for a standard authorisation is turned down will depend on the reason why the authorisation has not been given:

- If the best interests assessor concluded that the relevant person was not in fact being, or likely to be, deprived of liberty, no action is likely to be necessary.
- If the best interests assessor concluded that the proposed or actual deprivation of liberty was not in the relevant person's best interests, the Managing Authority will need to consider how the care plan could be changed to avoid deprivation of liberty (see paragraph 3). They should carefully examine the reasons given in the best interests assessor's report, and may find it helpful to discuss the matter with the best interests assessor. Where appropriate, they should also discuss the matter with family and carers. If the person is not yet resident in the hospital, the revised care plan may not involve admission to that facility.

- If the mental capacity assessor concluded that the relevant person has capacity to make decisions about their care, the Managing Authority will need to consider how to support the person to make such decisions.
- If the relevant person was identified as not eligible to be subject to a deprivation of liberty authorisation, it may be appropriate to assess whether an application should be made to detain the person under the Mental Health Act 1983.
- If the relevant person does not have a mental disorder as defined in the Mental Health Act 1983, an application to the Court of Protection must be considered since there would be no other lawful basis for depriving a person of their liberty in those circumstances.
- Where there is a refusal by an attorney under a valid Lasting Power of Attorney or deputy to the Court of Protection, or an applicable and valid advance decision, alternative care arrangements will need to be made. If there is a question as to whether the refusal is valid or concerns that an attorney or deputy may not be acting in the person's best interests, a decision may be sought from the Court of Protection.

Working out what action should be taken where a request for a standard deprivation of liberty authorisation is turned down in respect of someone whose care is not funded through the NHS may present particular problems, because the Managing Authority may not be able to make alternative care arrangements without discussion with those controlling the funding, whether relatives of the person concerned or others.

11 ENTITLEMENT OF ANY PERSON TO REQUEST CONSIDERATION OF A POTENTIAL UNAUTHORISED DEPRIVATION OF LIBERTY

If any person believes that someone is being deprived of their liberty without authorisation, they may raise this with the relevant authorities. This is an important safeguard for patients. In the first instance, the person should raise his or her concerns with the Managing Authority (ward based staff), and ask the Managing Authority to either request an authorisation. The Managing Authority must respond within a reasonable time to the request.

The third party may make a request to the Supervisory Body to determine whether there is an unauthorised deprivation of liberty, and the Supervisory Body can then arrange for an assessment to take place. The Managing Authority will be notified of the request and actions taken by the Supervisory Body, and of the outcome of the assessment. Where the findings of the assessment indicate that there is an unauthorised deprivation of liberty, immediate steps must be taken to ensure that it does not continue. Unless the Managing Authority is able to change the care arrangements to avoid deprivation of liberty, the full assessment process for a standard authorisation must now be carried out. The Managing Authority will follow the process for application for a standard authorisation, starting by sending the relevant information to the Supervisory Body. The Managing Authority may also give an urgent authorisation.

12 OTHER CIRCUMSTANCES WHEN APPLICATION FOR AUTHORISATION SHOULD BE MADE

(Welsh Govt. Guidance for Managing Authorities page 9)

A standard authorisation can be transferred along with the patient from one ward to another in the same hospital. If the patient is to be transferred to a different hospital then the receiving ward will need to make a new application.

Where the Court has authorised that a person can be lawfully detained but that authority is due to expire the Managing Authority must apply for a standard authorisation if the person continues to meet the qualifying requirements for a deprivation of their liberty.

13 THE SUPERVISORY BODY

13.4 Process to be followed by the Supervisory Body in respect of applications for standard authorisations of a deprivation of liberty:

- On receipt of a request for an application for a Standard Authorisation (see section 6) the documentation is logged as received and then forwarded to the Deprivation of Liberty Safeguards Coordinator for scrutiny to determine whether all appropriate information has been received.
  - The DoLS Coordinator, or their deputy, is responsible for prioritising DoLS referrals for allocation of assessors. Following the Supreme Court judgement in 2014 the demand for DoLS assessments increased 10 fold and nationally all Supervisory Bodies have been challenged by the need to balance scarce resources against their ability to meet their statutory duties under DoLS. Although there is nothing in the statute to allow for referrals to be prioritised, and therefore in some cases no assessment being undertaken, it has been recognised by national and devolved governments and health departments that a procedure to do just that is necessary. Hywel Dda University Health Board has developed a prioritisation tool based on work undertaken by the Association of Directors of Adult Social Services (ADASS) and on guidelines issued by the Law Society. The aim is to ensure that all those for whom the DoLS safeguards are most likely to be required have the benefit of an assessment. The Health Board's prioritisation tool will be kept under periodic review and audit to ensure that it remains fit for purpose. The tool can be found here: http://howis.wales.nhs.uk/sitesplus/862/page/71445
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- A mental health assessor (section 12 MHA 1983 approved doctor) is contacted and a request made for assessments to be completed. These include the mental health assessment and usual practice in this Health Board is for the mental health assessor to also undertake the mental capacity and eligibility assessments.
- An appropriately trained Best Interest Assessor (BIA) is contacted to facilitate a best interests assessment and in this Health Board usual practice is for the BIA to complete the no refusals assessment and age assessment.
- If the Managing Authority indicates that there is nobody appropriate to consult, other than professionals or paid carers, an IMCA is instructed to represent the patient by the Supervisory Body. Such an IMCA is referred to as a 'section 39A IMCA'. The IMCA's role will be to make representations to the assessors, and to provide a report to the Supervisory Body.
- On receipt of the completed assessments they are scrutinised by a nominated signatory within the Supervisory Body to determine whether or not an authorisation is required, and if required, an authorisation is given. Standard letters are then completed and signed off by the nominated signatory within the Supervisory Body. These are sent to the Managing Authority and copied to those individuals identified within the guidance.
- The Supervisory Body must set the period of the authorisation, which may not be longer than that recommended by the BIA (also taking into account any IMCA report). The Supervisory Body may attach conditions to the authorisation, taking into account any recommendations made by the BIA (and in any IMCA report).
- If an authorisation is given, it is the Supervisory Body's responsibility to appoint a representative for the relevant person as soon as practical and possible, in accordance with the recommendations made by the BIA. If the BIA has not been able to recommend anybody, the Supervisory Body must identify an eligible person, and may pay the person who is selected.
- If authorisation to deprive the person of their liberty is not given then the appropriate standard letters are completed and forwarded to the relevant persons.

- All outcomes and decisions are recorded on the appropriate database.

13.5 Process followed by Supervisory Body when an urgent authorisation has been given by the Managing Authority

- Where an urgent authorisation has been given by the Managing Authority, the Supervisory Body can (upon request from the Managing Authority) extend the duration of the urgent authorisation to a maximum of 14 days in exceptional circumstances.
- An urgent authorisation will terminate once a standard authorisation has been granted; it will also terminate if the Managing Authority receives notice that a standard notification will not be given.

13.6 Process to be followed by the Supervisory Body when a request is received to consider a potential unauthorised deprivation of liberty

- On receipt of a third party request to decide whether there is an unauthorised deprivation of liberty, the document is logged as received and forwarded to a nominated signatory for scrutiny as to whether an assessment should be carried out (see DoLS Code of Practice, para. 9.5).
- Standard letters are then sent out to the Managing Authority and the individuals identified in the guidance, notifying them of the request.
- If an assessment is to be carried out, a BIA is contacted, and an assessment to determine whether or not unlawful deprivation of liberty is occurring is completed within the timescales identified in the legislation.
- Where the patient is unbefriended, an IMCA is instructed to represent the person. Such an IMCA is referred to as a ‘section 39A IMCA’.
- On receipt of the completed assessment, it is scrutinised by a nominated signatory. The Managing Authority and individuals identified in the guidance must then be notified of the outcome.
- In the event that the assessment indicates unauthorised deprivation of liberty, the Supervisory Body now proceeds to complete a full assessment process as if a standard authorisation had been applied for.
- A record is made in the appropriate database.

13.7 Key safeguarding responsibilities of the Supervisory Body when a standard authorisation is in place

- Reviews must be held in accordance with the guidance.
- A review must be held where a request has been made by the Managing Authority, the patient, the representative, or any section 39C IMCA.
- A review may also be held where matters have been brought to the attention of the Supervisory Body which suggest that the relevant person no longer meets the qualifying requirements.
- The appointment of the Relevant Person’s Representative must be terminated in any of the circumstances set out in the DoLS Code of Practice paragraph 7.29, and a fresh appointment made as soon as is practical and possible.
- Where there is any gap in appointment and there is no-one appropriate to consult, an IMCA (referred to as a ‘section 39C IMCA’) must be instructed to take on the role of the relevant person’s representative during that gap in appointment.
- The relevant person and his or her representative are entitled to request support from an IMCA (referred to as a ‘section 39D IMCA’). It is the responsibility of the Supervisory Body to instruct an IMCA when there is such a request.

- A section 39D IMCA must also be instructed by the Supervisory Body if (a) it is believed that, without an IMCA, the person or their representative would be unable to exercise their right to apply to the court or to request a review of the authorisation or (b) it is believed that the relevant person or their representative would be unlikely to exercise their right to apply to the court or request a review of the authorisation when it would be reasonable to do so.

14 RESPONSIBILITIES

14.4 Chief Executive

The Chief Executive and Board hold ultimate responsibility for the implementation of the Deprivation of Liberty Safeguards within the Health Board.

14.5 Director of Primary Care, Community and Long Term Care

Executive responsibility is delegated to the Director of Primary Care, Community and Long Term Care who is responsible for the overall governance of the DoLS service and which is monitored through the Mental Capacity and Consent Group.

14.6 Head of Long Term Care

The Head of Long Term Care has management responsibility for the DoLS service, ensuring that this policy is adhered to through analysis of DoLS activity reports, audits and practise issues reports provided by the DoLS Coordinator.

14.7 DOLS Co-Ordinator

The DoLS Coordinator is responsible for the daily administration of the service and training staff in relation to this policy. The Coordinator is also required to maintain up to date knowledge of case law and statutory guidance in relation to DoLS to ensure that this policy remains relevant.

14.8 All Health Board staff

All Health Board staff receive DoLS awareness training as part of the mandatory Mental Capacity Act training. All staff have a responsibility to act in the best interest of those lacking the relevant mental capacity and this includes ensuring they have access to the DoLS process in accordance with this policy.

All Health Board staff working with and/or caring for an adult who may lack capacity to consent to their accommodation and care arrangements in hospital must comply with the Deprivation of Liberty Safeguards. Healthcare professionals have a legal duty to have regard to the Code of Practice.

15 TRAINING

Training in relation to the Deprivation of Liberty Safeguards is delivered as part of the training provided to clinical staff in respect of the Mental Capacity Act. For available course see the Learning & Development Risk Management Catalogue available at http://howis.wales.nhs.uk/sitesplus/862/page/43244.

The DoLS Coordinator and MCA Practitioner for your clinical area can provide informal advice or bespoke training upon request. For the relevant contact details visit the Mental Capacity Act intranet page at http://howis.wales.nhs.uk/sitesplus/862/page/48570 or DoLS Intranet page here: http://howis.wales.nhs.uk/sitesplus/862/page/68864

16 MONITORING

The processes surrounding the issuing of Urgent Authorisations and granting of Standard Authorisations must be clearly recorded and regularly monitored as part of the Supervisory Body's governance arrangements. This will be undertaken by the DoLS Coordinator who will prepare activity reports and collate related clinical practice issues in respect of the Safeguards. These will be reported to the Health Board's Mental Capacity Act Steering Group as standing agenda items for information or action as required.

DoLS activity will be audited against statutory and locally agreed targets.

The DoLS Coordinator will monitor changes to legislation and guidance in respect of DoLS and undertake a review of this policy where necessary to ensure it remains relevant and valid.

Annual audit data is provided to Health Inspectorate Wales who have responsibility for monitoring DoLS at a national level.

17 REFERENCES

Mental Capacity Act 2005 - http://www.legislation.gov.uk/ukpga/2005/9/contents, TSO: London

Mental Capacity Act 2005 Code of Practice - http://howis.wales.nhs.uk/sitesplus/documents/862/MCA%20CoP.pdf (2007), TSO: London.

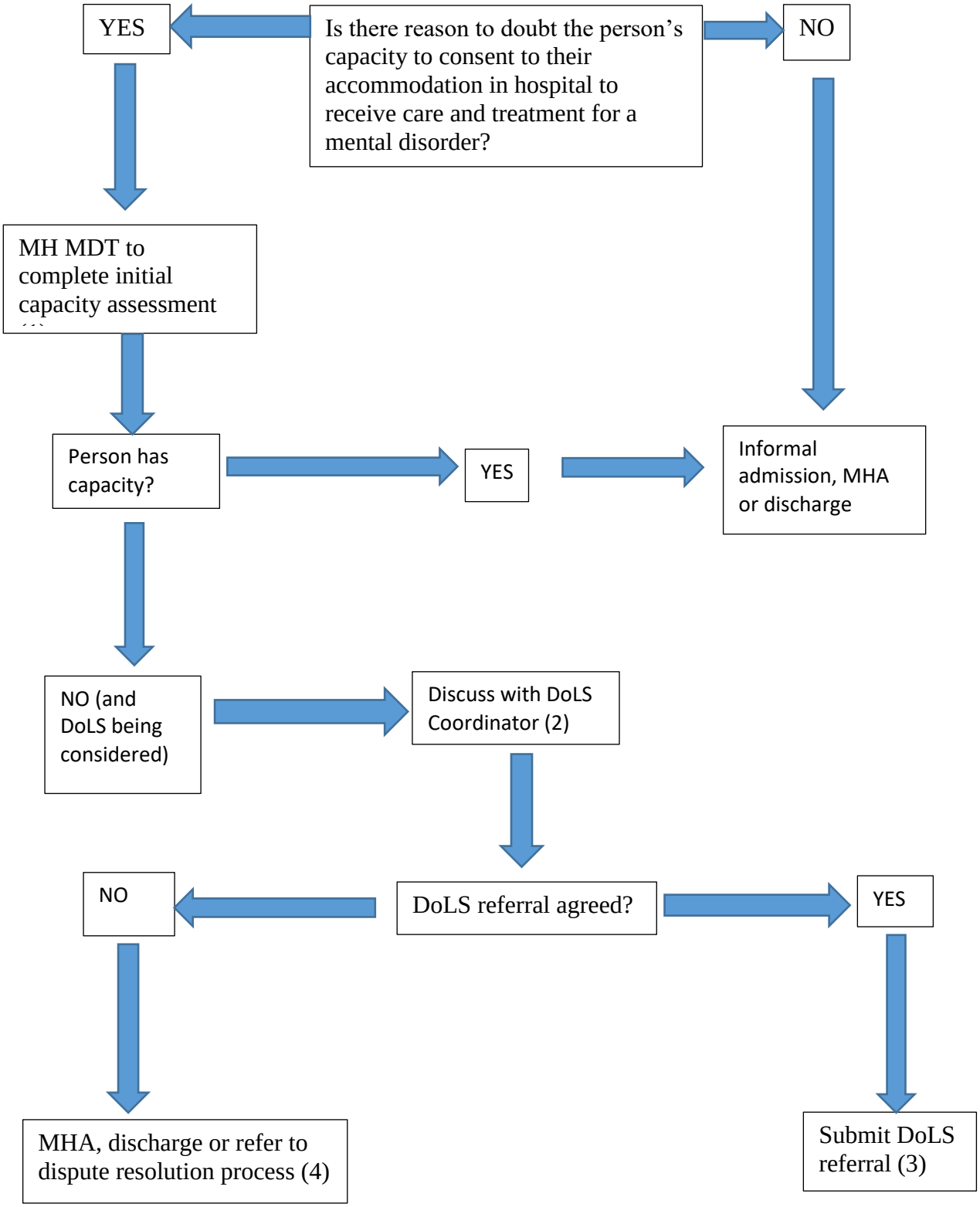
Deprivation of liberty safeguards. Code of Practice - http://howis.wales.nhs.uk/sitesplus/documents/862/DoLS%20Code1.pdf - to supplement the main Mental Capacity Act 2005 Code of Practice (2008), TSO: London.

Guidance for Managing Authorities - http://www.wales.nhs.uk/sites3/Documents/744/Guidance%20for%20Managing%20Authorities.pdf working within the Mental Capacity Act Deprivation of Liberty Safeguards (2009), Welsh Assembly Government: Cardiff.

Guidance for Supervisory Bodies - http://www.wales.nhs.uk/sites3/Documents/744/Guidance%20for%20Supervisory%20Bodies.pdf - working within the Mental Capacity Act Deprivation of Liberty Safeguards (2009), Welsh Assembly Government: Cardiff.

Law Society: deprivation of Liberty: a practical guide: https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

18 APPENDIX A



Guidance Notes for Flowchart

- Capacity assessment completion guidance here: http://howis.wales.nhs.uk/sitesplus/862/page/71445
- Capacity to consent to specific care and treatment, whether for a mental or physical disorder, must also be assessed if there is reason to doubt.
- Contact DoLS or MCA teams for advice on completion if required.

(1) Record decision to consider DoLS in Care Partner. Initial contact with DoLS service should be via phone call (01437 834469) or email (dols.hdd@wales.nhs.uk) as soon as DoLS is considered by the RC/MDT, and before a DoLS referral is completed. If currently detained under the MHA the person's IMHA **must** be consulted by the RC/MDT.

- The purpose of the discussion is to establish if there are any issues that may prevent a DoLS Authorisation being given e.g. objection or risk to others.
- By having an early discussion most issues can be resolved in a timely manner preventing any gaps in legal authority to deprive the person of their liberty
- Will ensure good use of both DoLS and MH service resources, avoiding the need for ward staff to complete unnecessary DoLS referrals, or preventing duplication of assessments e.g. DoLS Eligibility Assessment followed by MHA Assessment.

(2) Current DoLS referral form can be accessed here: http://howis.wales.nhs.uk/sitesplus/862/page/71445
- Email completed form to DoLS.hdd@wales.nhs.uk
- Ward should upload copy of referral to Care Partner

(3) If immediate agreement cannot be reached on whether a DoLS referral is appropriate:
- If currently detained under a section of the MHA this should wherever possible remain in place while a resolution is reached.
- Ward will submit DoLS Standard Authorisation (SA) referral.
- If not currently subject to MHA use Urgent Authorisation process (UA plus SA referral submitted)
- Supervisory Body will allocate assessors as soon as possible.
- If on assessment person does not meet DoLS Eligibility criteria a MHA assessment may need to be arranged.
- If agreement on the appropriate regime still cannot be reached the matter must be escalated and legal services approached for advice as soon as possible. The DoLS Coordinator will have responsibility for referring to legal services for assistance.