NHS FRIMLEY INTEGRATED CARE BOARD

DEPRIVATION OF LIBERTY ACT SAFEGUARDS POLICY AND PROCEDURE

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Equality Statement

Frimley Integrated Care Board aims to design and implement services, policies and measures that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who have shared a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

We embrace the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

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1. Introduction

1.1 The NHS Frimley Integrated Care Board (ICB) uses policies and procedures to enable staff working for and with us, to do so in a way that is efficient, consistent, safe and in keeping with our values, objectives, and purpose.

1.2 This policy applies to all staff employed by Frimley ICB East Berkshire Continuing Healthcare (CHC), including any agency or temporary staff. Managers must ensure that staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

1.3 The Deprivation of Liberty Safeguards (DoLS) were introduced to provide a legal framework around the deprivation of liberty. Specifically, they were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgement of the European Court of Human Rights in the case of HL v the United Kingdom, commonly referred to as the 'Bournewood Judgement'. HL v UK 45508/99 [2004] ECHR 471 - Mental Health Law Online

1.4 Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. The DoLS were brought into force in April 2009 to ensure that professionals applied checks and balances when they had to deprive people lacking capacity of their liberty.

1.5 This policy should be read in conjunction with the:

Mental Capacity Act: Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Deprivation of Liberty Safeguards (DoLS): Code of Practice
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH085476

2. Purpose

2.1 The purpose of this policy is to assist the CHC Service when having discussions with people about Deprivation of Liberty (DoL) in community settings.

2.2 In addition, this policy provides detail on how the legal obligations regarding the Community Deprivation of Liberty Safeguards (Comm DoLS) will be met by the ICB and CHC Services.

2.3 This guidance has been developed for practitioners to help determine if the level of **restriction or restraint** within the provision of care and accommodation for clients **amounts to a deprivation**. And relates specifically to clients who are **living in settings other than hospital or care homes**, referred to as *community settings*. These will include:

- Supported living.
- Extra care housing
- Shared lives
- A person's own home.

3. Scope

The Deprivation of Liberty Safeguards apply to people who are **18 years and over** who: **Are being cared for in a domestic setting and receiving fully funded care and/or treatment funded by the CHC Service**. In 2014, the Supreme Court agrees an 'acid test' for people who are lacking capacity to consent to or refuse their care arrangements – (P v Cheshire West and Chester Council and Q v Surrey County Council, (2014 UKSC 19).

The 'acid test' states that an individual is deprived of their liberty if they:

- Lack the capacity to consent to these arrangements for their care/treatment.
- Are not free to leave.
- Are under continuous supervision and control.

4. Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain. An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment
- A substance misuse.

Lacking capacity is about the ability to make a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

5. Definition of Deprivation of Liberty

There is no simple definition of deprivation of liberty. The question of whether the steps taken by staff in relation to a person amount to a deprivation of that person's liberty is ultimately a legal question, and only the courts can determine the law.

This guidance seeks to assist staff in considering whether the steps they are taking, or proposing to take, amount to a deprivation of a person's liberty. The deprivation of liberty safeguards gives best interests assessors the authority to make recommendations about proposed deprivations of liberty, and supervisory bodies the power to give authorisations that deprive people of their liberty.

6. Deciding whether an authorisation may be needed

Initially, the practitioner must decide if an authorisation is required. (P will be used to denote the relevant 'person/client').

Please note that a Referral Checklist (Chapter 7) must run alongside existing CHC assessments, and Decision Support Tool (DST) activities, each case must be judged on its own merits with an awareness of the legal criteria required for the Community Deprivation of Liberty Safeguards.

1.	**Checklist to help decide if a DOLS authorisation is needed**
1.	Is P aged 18 years or above?
2.	Does P have an impairment of the mind or brain (e.g., mental illness, acquired brain injury, dementia)?
3.	Does P lack capacity to consent to accommodation or care and support?
4.	Is P subject to any powers of the Mental Health Act that would conflict with a DoLS authorisation?
5.	Are there any other valid decision-making authorities in place, e.g., advance decision, Lasting Power of Attorney, Court Appointed Deputy, that would conflict with a Court of Protection authorisation?

2.	**Application of the 'Acid Test'. Are there measures in place which restrict the person's freedom of movement?**
1.	P is under close observation or supervision, 1:1 and/or is not able to decide on a daily activity.
2.	P is prevented from leaving the community setting or is brought back if they try to leave.
3.	Equipment is in place which restricts movement or access, e.g., bed rails, locked doors, CCTV, coded keypads.
4.	P is not able to decide who they have contact with.
5.	P is accompanied by a member of staff when they access the community to support and meet their care needs.
6.	Restricted access to finances, with money being controlled by staff or benefits appointee.
7.	Access is restricted to types of communication such as internet, mobile or landline phones.
8.	Physical intervention techniques are being applied.
9.	P has covert medication, including sedatives.

3.	**Consideration should be given to the severity and impact of restrictions. Are they significant?**
1.	Are the restrictions used frequently and/or for prolonged periods of time?
2.	Do the restrictions impact significantly on the person's freedom of movement?
3.	Could there be a significant psychological impact on P, for example are they objecting or distressed?
4.	Are relatives or carers concerned about the restrictions placed on P?

4.	Are the restrictions considered to be in the person's best interests?
1.	Are they to protect the person from harm?
2.	Are the restrictions a proportionate response to the likelihood and severity of the potential harm?

Has consideration been given to reducing or eliminating the restrictions, so they are the least restrictive option

If it is possible to minimise the restrictions, any necessary actions needed to do this must be carried out immediately. Any remaining restrictions must be monitored closely and kept under review.

If it is not possible to reduce restrictions to a degree that no longer constitutes a DoL, according to the 'Acid Test' and they *ARE* in P's best interests, a Safeguarding Alert would need to be considered.

7. Referral Checklist

When a patient is identified as potentially being deprived of their liberty, the Nurse Assessor completes the Referral Checklist and returns it to frimleyicb.dols-lps@nhs.net

P's Details				
Broad Care No.	Name	Date of Birth	NHS No.	Address

Questions	Y/N	Notes	
1. Is P in a community-based placement, such as supported living, own or parental home, shared lives etc?			
2. Is P over the age of 18 years?			
3. Does P meet the following criteria: **a.** lack capacity to make decisions about their care and support needs? **b.** is subject to continuous supervision and control? (Under observation for a non-specified period?) **c.** P is unable to leave their care setting as and when they want?			
4. In reference to the Checklist – what is the level of Priority? (Refer to Appendix 3)	High	Medium	Low

Send the completed referral checklist to: frimleyicb.dols-lps@nhs.net	Date sent:
Identified Risks/ further information	

Practitioners signature: Date:

8. Completing a Community CoP DoL application

1. Referrals should be sent by the Nurse Assessor to the DoLS Team on the appropriate referral form. (See above and Appendix 1).
2. The DoLS Team will be responsible for prioritising Community DoL in accordance with the prioritisation tool (Appendix 2).
3. Nurse Assessor to record on CHC Database that a referral has been made to the DoLS Team.
4. In conjunction with the DoLS Assessor, the following points will be considered:
   a) The adult lacks capacity to make the relevant decision.
   b) The adult is fully funded through CHC.
   c) All relevant parties have been consulted and their views considered when determining an adult's best interests.
   d) Consideration regarding whether an Independent Mental Capacity Advocate (IMCA) may be required.
   Overview | Decision-making and mental capacity | Guidance | NICE
   e) Any restraint is necessary and proportionate to the likelihood and seriousness of harm.
   f) That a less restrictive option has been considered that will meet the assessed needs.
   g) Whether the adult or a family member is disputing a best interest's decision regarding residence, care, or contact.
   h) This list is not exhaustive and additional information may be requested.

9. Documentation

For Court of Protection applications regarding deprivation of liberty in a domestic setting or supported living arrangements and where there is **no objection** to the placement, the following documents will be required: Deprivation of Liberty orders - GOV.UK (www.gov.uk)

COPDOL11 Form

- All documents required by the Court of Protection are completed by the DoLS Assessor.
- The form is made up of **3 Annexes that form the evidence**. The annexes need to be signed and dated by the DoLS Assessor completing the form.
- In **Annex B**, there is a requirement to consult with relevant people involved in the person's life and care and support. This can be family, medical staff and placement staff.
- There is a need to identify someone as the person's representative **Rule 1.2 representative** as per the Court of Protection Rules 2017. This is someone that needs to be the eyes and ears on the ground. They must be willing to raise any issue about the care and support that the person is receiving. (Whomever is chosen needs to be provided with a copy of the Judgement in the case of *Re VE. Mr Justice Charles*).

COP 3 Mental Capacity Assessment Form

This needs to be completed by the DoLS Assessor and covers the person's ability to make decisions about their care and residence. Form COP3: Make a report on someone's capacity to make decisions - GOV.UK (www.gov.uk)

Medical practitioner evidence

- Completed by P's General Practitioner (GP), confirming that the person has a diagnosis of *'unsoundness of mind'*.
- The evidence provided by the GP is to be on headed paper that is signed and dated.

Best Interest Decision

- For the person to reside in his/her current placement.

Care and Support Plan

- This must be **signed and dated on each page** and must give the address of the placement.

COP24 Witness Statement

- A person identified by the DoLS Assessor to act as the Rule 1.2 Representative, and why they are suitable. They have been provided with the information from the Department of Health regarding the responsibilities (Re: VE)
- If there are no objections to the proposed care arrangements that amount to a deprivation of liberty, then the matter should progress on the papers. Once the application has been issued the papers are then sent for judicial consideration at which point the court can either make further directions or the final order. If the court makes further directions, these are usually received back quickly from the court. The Final Order however can take some time.
- The Rule 1.2 rep will have to provide a fresh COP24 witness statement every year. The Orders are generally in place for a 'review' period of 12 months.
- The review application will effectively be the same documents as set out above however there may be some concession with the COP3 Mental Capacity Assessment if the individual has a diagnosis that is not going to change or has indeed not changed for some time. (This can be advised on at the time of a review application).

10. When should an Independent Mental Capacity Advisor (IMCA) be instructed?

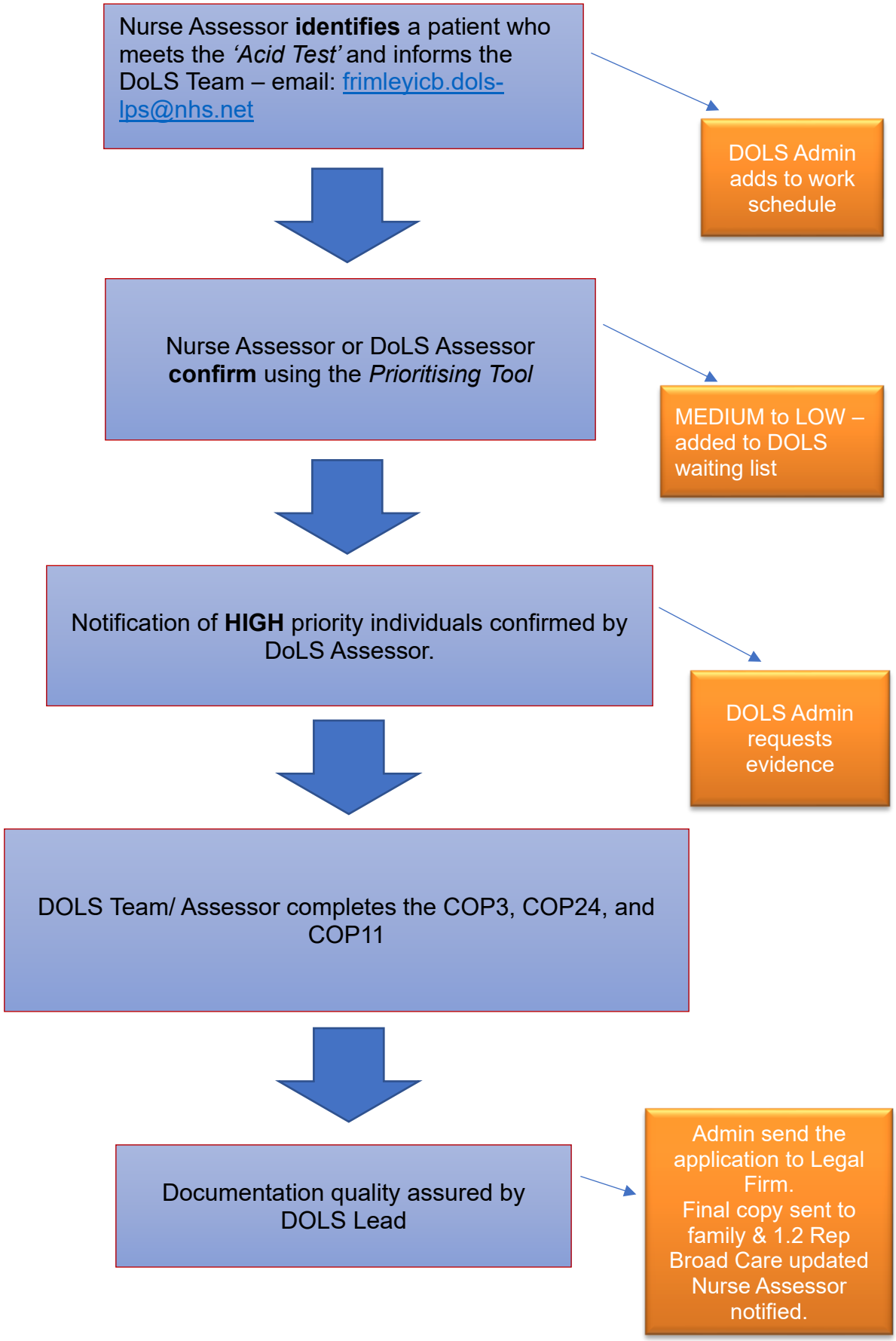
If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity, the CHC Service must instruct an IMCA to represent P when it submits the application for the deprivation of liberty. It is particularly important that the IMCA is instructed quickly so that they can make a meaningful input at a very early stage in the process.

Once a relevant person's representative is appointed (see DoLS: Code of Practice, chapter 7), the duties imposed on the IMCA cease to apply.

11. Appealing against an authorised deprivation of liberty

Everyone who has a Deprivation of Liberty Safeguards (DoLS) authorisation has a 'Relevant Person's Representative' appointed as part of the assessment process. The representative supports the person with all aspects of the DoLS, which will include helping with appeals or requesting a review if needed. A person subject to a DoLS authorisation is entitled to legal representation if they want to challenge their authorisation in the Court of Protection. A solicitor will be able to advise them on this process and on the availability of Legal Aid.

12. Community DoLS Referral Process



13. Mental Capacity Act/DoLS Training

The Department of Health has developed a suite of training packages to support the implementation of DoLS. The type of training that you will need depends on how involved you are working with people who may lack capacity and the need for and use of Deprivations of Liberty in your work setting.

It is recommended that CHC registered health care staff are trained at Level 3 (or above) in the Mental Capacity Act.

To assist ICBs in developing or reviewing current training packages to ensure that CHC registered health care staff have the appropriate expertise in the Mental Capacity Act and Deprivation of Liberty Safeguards/Liberty Protection Safeguards, NHS England have devised the following quick guide from the information currently available:

The reference to Level 3 is in keeping in line with the competency framework set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document.

The Intercollegiate states:
All registered health and social care staff working with adults who engage in assessing, planning, intervening, and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role) should at a competency level of 3.

Specific Competency levels relevant to the Mental Capacity Act are:

- **L3.2 Core competencies**
  - Undertakes capacity assessments within the framework of the relevant legislation (if appropriate to role) and can understand who needs to be included or consulted with in making decisions in a person's best interests.
- **L3.3 Knowledge, skills, attitudes, and values**
  - Understand the implications of legislation, inter-agency policy and national guidance.
  - Understands the notion of proportionality recognising that unforeseen events occur, and people can take risks and make unwise decisions.
- **L3.3.1 Skills**
  - Able to communicate effectively with adults to recognise and to ensure those lacking capacity to make a particular decision or with communication needs have opportunity to participate in decisions affecting them.
  - Able to communicate effectively with adults to recognise and to ensure those lacking capacity to make a particular decision or with communication needs have opportunity to participate in decisions affecting them.

The NICE guidance for decision-making and mental capacity also sets out topics which should be included in Mental Capacity Act training. **The NICE guidance also recommends training programmes should be co-developed with people who have experience of supported decision-making and of having their mental capacity assessed, and their carers, family, and friends**.

We also recommend utilising the National Mental Capacity Act Competency Framework Staff Competency level Group C: for Professional Health & Social Care Staff (Qualified non specialist) which includes ICB and LA commissioners and contract managers which states all staff should have expertise in:

1. Presuming Capacity

- A thorough knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice. They should always begin from the presumption that individuals have capacity to make the decision in question.
- Understand how to make a capacity assessment, the decision and time specific nature of capacity and hence the need to reassess capacity appropriately. They should know when and how to refer on.

2. Helping the person to make their own decision

- Recognise where general or independent mental capacity advocates (IMCA) may be appropriate and beneficial to support a person to make a decision.
- Use a range of communication methods to help people make their own decisions wherever possible.
- Seek specialist communication support where necessary.
- Understand how principle 2 links to the personalisation and Care Act 2014 responsibilities for supported decision making and co-productive approaches.
- Understand their responsibilities for people who are assessed as lacking capacity at a particular time and must ensure that they are supported to be involved in decisions about themselves and their care as far as is possible.
- Where they are unable to be involved in the decision-making process, decisions should be taken in their best interests following consultation with all appropriate parties, including families and carers. Social workers must seek to ensure that an individual's care plan is the least restrictive possible to achieve the intended outcomes, Department for Health and Social Care's, Knowledge, and Skills Statement 5 – (KSS 5).
- Understand the likely impact of coercion on someone's mental capacity (Regardless of whether they have an impairment of their mind or brain).

3. Unwise Decisions

- Knowledge of the Human Rights Act 1998.
- Where there is no concern over capacity, social workers should take all practicable steps to empower people to make their own decisions, recognising that people are experts in their own lives and working alongside them to identify person-centred solutions to risk and harm, recognising the individual's right to make "unwise" decisions (KSS 5).

4. Best Interests

- Knowledge of the Care Act 2014 and the Well-being principle and then application in situations where mental capacity and best interests are in question.

5. Less Restriction

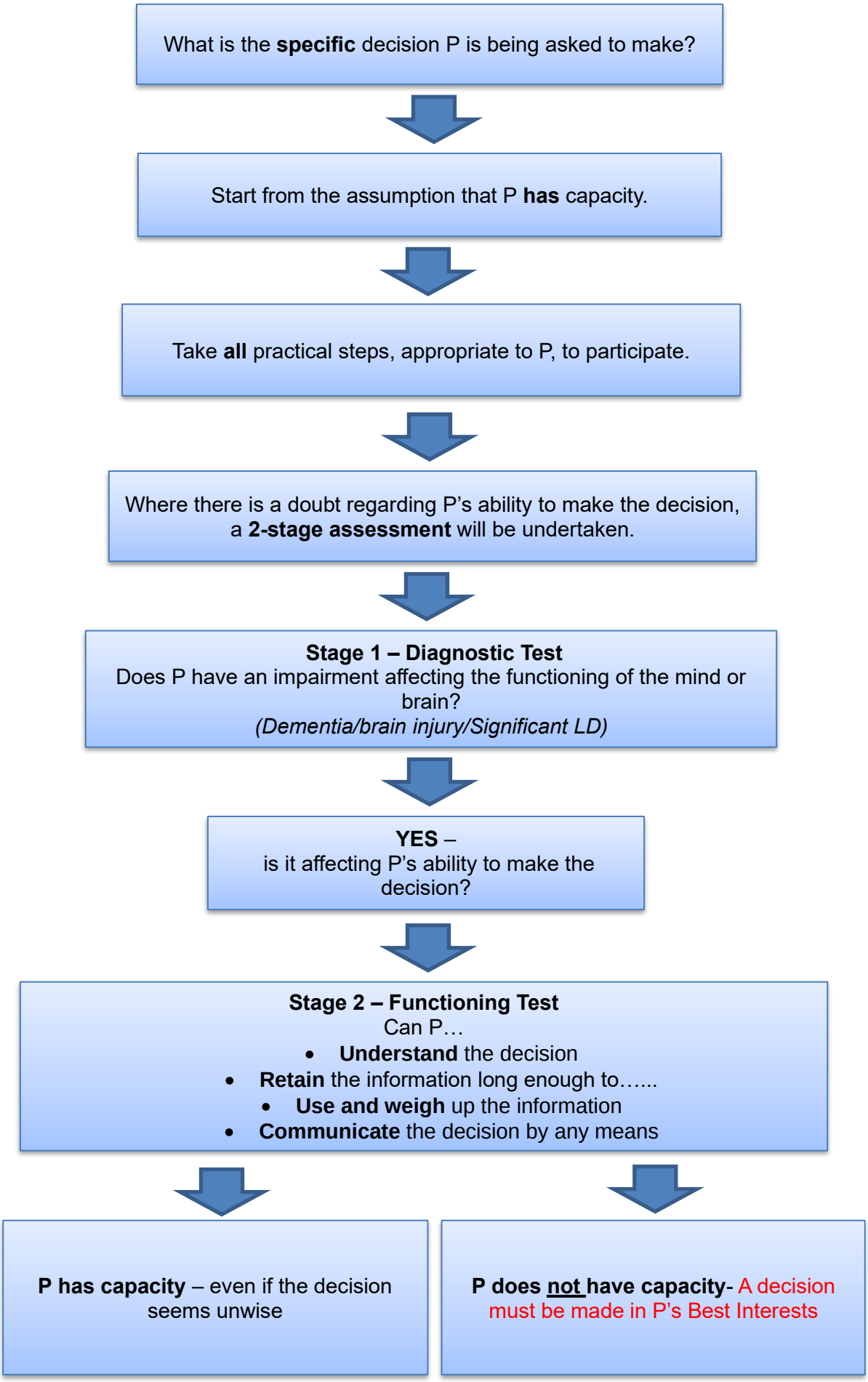
- Recognise restrictions being placed on an individual and assess whether these are proportionate to the person's needs and risks of harm.
- Attend and contribute to investigations/meetings/information sharing.
- Understand that the MCA exists to empower those who lack capacity as much as it exists to protect them. Social workers must model and lead a change of approach, away from that where the default setting is "safety first", towards a person-centred culture where individual choice is encouraged and where the right of all individuals to express their own lifestyle choices is recognised and valued (KSS 5).

The Liberty Protection Safeguards Training Framework

The aim of the training framework is to support the development and delivery of appropriate education and training to support the implementation and launch of the LPS. Although the LPS has been delayed, in the meantime, the framework provides a useful description of the core skills and knowledge that are relevant to the workforce who need to have an awareness and understanding of deprivation of liberty safeguards within the context of the wider Mental Capacity Act 2005 (MCA).

LPS-training-framework-england.pdf

Mental Capacity Act 2005 – Assessing Capacity Flowchart



Appendix LOGO

Date

Re: Further Application to the Court of Protection
Dear
(Copies to Rep 1.2, family, and care providers, as required)

The Final Sealed Order for (name) has been received from the Court of Protection, and we have attached a copy. This is in accordance with the legislative requirements.

The Community Deprivation of Liberty Authorisation for (name) will be valid for 12 months and is due to expire on (date). The Order requires the ICB/CHC to make a further application to the Court no less than one month before the expiry date of the Review Period.

Therefore, if the care arrangements for (name) continue to require the Court's Authorisation, we will arrange to undertake a further Community Deprivation of Liberty Review and submit the completed documentation (as we did previously), to the Court of Protection.

In the meantime, the CHC Nurse Assessor will be undertaking a Care Plan Review and document any restrictions that are assessed as being necessary and proportionate to support (Name) care and support requirements.

Signed

Glossary

Acid Test	This test defines what constitutes a Deprivation of Liberty. Established under the 'Cheshire West' ruling; the Supreme Court ruling; the Supreme court ruling on 19th March in P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19. Is the person: Unable to make decisions about their care and residence due to a lack of capacity. Subject to continuous control and supervision. AND, not free to leave.
Assessments	There are 6 assessments that need to be undertaken as part of the Community DoLS authorisation process. The Best Interest Assessor will undertake the assessments.
Authorisations	The authority to legally hold someone in a community or domestic setting under the DoLS. There are two types; standard or streamlined. The authorisation for deprivation of liberty should be for the shortest possible practicable time but can extend for up to 12 months.
Authorising Signatory	The person who is responsible for checking completed assessments from DoLS assessors and granting standard authorisations.
Best Interests	Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests. These are set out in section 4 of the Act, and in the non-exhaustive checklist in 5.13.
Best Interests Assessor (BIA)	A health or social care professional with an additional qualification to undertake the assessments to consider whether a deprivation of liberty would be in the relevant person's best interests.
Bournewood Judgement	The commonly used term for the October 2004 judgment by the European Court of Human Rights in the case of HL v the United Kingdom that led to the introduction of the deprivation of liberty safeguards.
Consent	The voluntary and continuing permission of the person to receive particular treatment or care and support, based on adequate knowledge of the purpose, nature, likely effects and risks including the likelihood of success, any alternatives to it and what will happen if the treatment does not go ahead; permission given under any unfair or undue pressure is not consent – by definition, a person who lacks capacity to consent does not consent to

	treatment or care and support, even if they co-operate with the treatment or actively seek it). consent | Search results | NICE
Continuing Healthcare (CHC)	NHS continuing healthcare, refers to a package of ongoing care arranged and funded solely by the NHS where it has been assessed that the individual's primary need is a health need. In a person's own home, it means that the NHS funds all the care required to meet the person's assessed health needs. In care homes, it means that the NHS enters into a contract with the care home and pays the fees for the person's accommodation as well as all their care.
Court Appointed Deputy	A person appointed to act and make decisions on behalf of someone who lacks capacity to make those decisions.
Court of Protection (CoP)	The Court that governs the Mental Capacity Act including the Community DoL. It can make decisions and what is in the best interests on behalf of people who cannot make their own decisions because of something affecting their mind or brain. CoP is established under section 45 of the Act.
Decision-maker	Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code, as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.
Deprivation of Liberty	The term used in Article 5 of the European Convention on Human Rights which states that everyone has the right to liberty, and it can only be taken away in certain circumstances and only if legal processes are used.
Deprivation of Liberty Safeguards (DoLS)	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty. The legislation provides the procedures and sets out the rules governing a deprivation of liberty authorisation.
Community Deprivation of Liberty	For people in supported living, at home or in a hospital, a deprivation of liberty will need to be authorised by the Court of Protection rather than by a Local Authority.
Independent Mental Capacity Advocate (IMCA)	A specialist advocate who can represent the person and their best interests if they have no family or friend to speak on their behalf. There is a statutory duty to refer to an IMCA in certain circumstances.
Lasting Power of Attorney	A legal document that allows one person to give another person the authority to make decisions on their behalf.

Mental Capacity Assessment	An assessment, for the purpose of the Deprivation of Liberty Safeguards, of whether a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant community setting for the purpose of being given care or treatment.
Restraint	See Section 6(4) of the Act. The use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
Supervisory Body	Supervisory Bodies are those organisations that can authorise a DoLS. This will be the Local Authority where the patient is residing.
Managing Authority	An NHS ICB organisation such as Frimley ICB who fund and/or provide care and support for people.
Mental Capacity	The ability to make a specific decision at the time the decision needs to be made.
Mental Health Assessor	A medically trained professional appointed by the Supervisory Body to consider whether the relevant person is suffering from any disorder or disability of mind that would cause doubt around the person's ability to consent to their admission to a hospital or care home for the proposed care and treatment.
Relevant Person	The person who is or may be the subject of a Deprivation of Liberty regime and may be either a patient in a hospital or a resident in a care home.
Relevant Person's Representative (RPR)	The role of the RPR is to maintain contact with the Person and to represent and support them in all matters relating to the deprivation.
Restraint	Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
Under 18's	Following the supreme Court ruling on 26th September 2019 in the matter of D (a child), parental consent is insufficient to deprive a 16- or 17-year-old of their liberty and a Court of Protection Order is required if the young person's arrangements meet the Acid Test. High Court involvement may also be required in the case of someone under 16.

Resources

Department of Health

Publishes guidance for healthcare and social care staff in England. Key publications referenced in the Code include:

- on using restraint with people with learning disabilities and autistic spectrum disorder, see Guidance for restrictive physical interventions www.dh.gov.uk/assetRoot/04/06/84/61/04068461.pdf
- on adult protection procedures, see No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse www.dh.gov.uk/assetRoot/04/07/45/44/04074544.pdf
- on consent to examination and treatment, including advance decisions to refuse treatment www.dh/gov.uk/consent
- on the proposed Bournewood safeguards, a draft illustrative Code of Practice www.dh.gov.uk/assetRoot/04/14/17/64/04141764.pdf
- on IMCAs and the IMCA pilots www.dh.gov.uk/imca DH also is responsible for the Mental Health Act 1983 Code of Practice (TSO 1999) www.dh.gov.uk/assetRoot/04/07/49/61/04074961.pdf

The Mental Capacity Act 2005

https://www.legislation.gov.uk/ukpga/2005/9/contents

The Mental Capacity Act: Code of Practice

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Deprivation of Liberty Safeguards (DoLS): Code of Practice

http://webarchive.nationalarchives.go.uk/20130107105354/http;/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 085476

Standard Operating Procedure for Community Deprivation of Liberty Authorisation

Standard Operating Procedure for Commu

Priority Screening Tool

A screening tool to prioritise applications.

DoLS Information Handout

DoLS_InformationHandout.pdf

Capacity Assessment template

Assessment of Capacity template.doc