Department of Health

22 October 2015

Department of Health Guidance:
Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards

Contents

This guidance covers:

Background

1. The Supreme Court judgment of 19 March 2014 in the case of Cheshire West clarified an "acid test" for what constitutes a "deprivation of liberty"[1].

2. The acid test states that an individual is deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights if they:

   - Lack the capacity to consent to their care/ treatment arrangements

[1] *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council*, http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

- Are under continuous supervision and control
- Are not free to leave.

3. All three elements must be present for the acid test to be met.

4. A deprivation of liberty for such a person must be authorised in accordance with either the Deprivation of Liberty Safeguards (DoLS – part of the MCA), or by the Court of Protection or, if applicable, under the Mental Health Act 1983 (MHA).

5. The Supreme Court further held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection to the proposed care/ treatment and the reason or purpose behind a particular placement. It was also held that the relative normality of the placement, given the person's needs, was not relevant. This means that the person should not be compared with anyone else in determining whether there is a deprivation of liberty.

6. The Supreme Court also held that a deprivation of liberty can occur in community and domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement. Hence, where there is, or is likely to be, a deprivation of liberty in such settings, this should be authorised by the Court of Protection.

7. The Court of Protection has held that the acid test also applies in acute non-psychiatric hospital settings.[2]

Practical implications

8. The recently published annual report from the Health and Social Care Information Centre (HSCIC) confirms that, following the Supreme Court judgment, DoLS applications have risen approximately ten-fold. In 2013/14 (the year prior to the judgment) there were approximately 13,700 applications. In 2014/15 (the year following the judgment) there were 137,540. Of these, 62,645 applications were completed by local authorities during the year, almost five times as many as in 2013-14. The full statistics can be found at the following link: http://www.hscic.gov.uk/searchcatalogue?productid=18910&q=Mental+Capacity+Act+2005%2c+Deprivation+of+Liberty+Safeguards+(England)&sort=Relevance&size=10&page=1#top

9. The increase in applications reflects significant extra activity for health and care providers (who must submit requests for DoLS authorisations and Court of Protection applications) but particularly for local authority teams who have responsibility for assessing requests for authorisations and where appropriate, authorising any deprivation of liberty.

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[2] *NHS Trust & Ors v FG* [2014] EWCOP 30, http://www.bailii.org/ew/cases/EWCOP/2014/30.html

10. It is also clear from the HSCIC statistics that due to the significant increase in requests for authorisations, many local authorities are struggling to process these within the legal time limit.

Overall DH Guidance

11. The Department of Health's priority is the well-being of individuals in health and care settings who may lack capacity and are subject to restrictive care.

12. The Department remains supportive of the DoLS system in that it provides a mechanism by which the care of an individual who lacks capacity to consent to restrictions that amount to a deprivation of liberty can be independently scrutinised to ensure such restrictions are in that person's best interests and that no appropriate less restrictive alternative exists.

13. DoLS is part of, and rooted in the principles of, the wider MCA. The response to the Supreme Court judgment should similarly be based in the principles of the MCA. DoLS assessments should continue to be person-centred and consider the unique situation of each individual. "Bulk assessments" for example are not appropriate.

14. It is clear that implementing the Supreme Court judgment is a journey – such a significant change in front-line practice could never be brought about overnight. The Department and our partners including the Association of Directors of Adult Social Services (ADASS) and the Care Quality Commission (CQC) are clear however, that providers and local authorities should have a plan in place for how to respond to the judgment. A "do-nothing" approach is not acceptable.

15. This plan will inevitably involve an element of prioritisation to ensure that those individuals most likely to benefit from a DoLS application and assessment are afforded attention in a timely manner. ADASS has developed a prioritisation tool that will help in this[3]. It is particularly important, given the level of applications being made, that robust procedures are in place to ensure that particularly vulnerable individuals can be identified rapidly and appropriate action taken.

16. Health and care providers will understandably be concerned should applications made to local authorities not be assessed within statutory time-limits. Whilst this is not ideal, it is an inevitable consequence of the unexpected large increase in applications that local authorities are now charged with processing. Providers should not delay in sending DoLS applications to local authorities for individuals whose circumstances they believe may meet the Supreme Court's acid test.

17. Fundamentally, it is the Department's view that providers that can demonstrate that they are providing good quality care/ treatment for individuals in a manner compliant with the

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[3] ADASS Prioritisation Tool
http://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health/key_documents/DoLS%20Guidance%20note%20November%202014.pdf

principles of the MCA, and who are following DH and other national guidance, should not be harshly treated for technical DoLS breaches.

18. CQC will assess providers on a case by case basis where their DoLS applications have not been responded to within the statutory time-limits. CQC will expect to see that providers are submitting applications for any individuals being deprived of their liberty without delay, and that they are continuing to seek less restrictive options for those individuals' care or treatment in the meantime. Services should be working with local authorities to ensure that appropriate prioritisation of individuals most likely to benefit from a DoLS assessment is taking place[4].

19. While recognising the increased workload on providers and local authorities and appreciating the great professionalism and commitment to service-users shown by staff since the Supreme Court judgment, the Department does believe the current situation presents a valuable opportunity to embed principles of least restrictive person-centred care and provide independent scrutiny of the care arrangements for a cohort of potentially vulnerable individuals.

20. There remains a considerable challenge in communicating the facts about DoLS – that a DoLS assessment in itself is a positive tool for ensuring restrictive care is only used where appropriate. It would seem to be a clear priority for local authorities to be well-positioned to provide professionals but especially family and individuals with key information on the DoLS process.

21. The Department has begun steps to review the DoLS legislation but we must not allow this to deflect attention from our efforts to respond now to the Supreme Court judgment in a manner that puts individuals first and foremost.

Specific Guidance

<u>Intensive care and accident & emergency settings</u>

22. A "deprivation of liberty" must be "attributable to the state" to require use of DoLS. Intensive care, A&E and acute non-psychiatric settings are of course included.

23. However, the Department is aware that the operation of DoLS within these settings is causing some concerns. It may be helpful for professionals to remember:

    - Providers can self-authorise a deprivation of liberty for up to seven days by following the "Urgent Authorisation" process under DoLS.

[4] CQC Annual Report on DoLS 2013/14

http://www.cqc.org.uk/content/deprivation-liberty-safeguards-201314

- It is clear from ECHR case law that a person must be confined to a particular restricted place for a "non-negligible period of time" for there to be a deprivation of liberty. There is no set definition of this period – providers may want to establish a working definition as part of their policy and procedures for responding to the Supreme Court judgment.

- In an emergency situation where the person lacks capacity to consent, care and treatment should not be delayed. Professionals should proceed in the best interests of the individual in line with the MCA.

- A deprivation of liberty will only arise where an individual lacks capacity specifically to consent to the care/ treatment arrangements that give rise to a deprivation of liberty. It is incorrect to assume that all individuals with a mental disorder will lack the capacity in this specific respect.

- Professionals will also wish to be aware that DoLS can only be used where the individual in question has a mental disorder within the meaning of the Mental Health Act (but disregarding any exclusion for persons with learning disability). The Department has stated that it does not consider a state of unconsciousness in itself as being a mental disorder for the purposes of Schedule A1 to the MCA. The implications are that an individual who is unconscious under anaesthetic but does not have a mental disorder is not eligible for DoLS.

End-of-life and palliative care settings

24. End-of-life and palliative care settings are another area where the Supreme Court judgment has led to particular difficulties. Individuals in these settings have as much right to least restrictive, best interests care as in any other health and care setting. However, handled inappropriately, the DoLS process can cause unnecessary distress for the individual and their family and friends.

25. We must remember that the reality on the ground is, that in the great majority of palliative care cases, the family and loved ones of the individual concerned do not recognise any "deprivation of liberty" in a conventional sense. Rather, they see a normal care situation.

26. It is important that those professionals working in palliative care and end-of-life settings understand where it is not appropriate to make a DoLS application. Professionals should feel confident of their position if they are following good MCA principles, this guidance and are keeping good records of decisions made.

27. If a person has the capacity to consent to the care/treatment arrangements (even if they lack capacity to make decisions on other matters), and does consent, then there is no deprivation of liberty.

28. This applies to all care situations, not just palliative care. Some professionals are not clear on this point and there have been incorrect assertions such as “everyone here has dementia, they must all be deprived of their liberty”.

29. Specifically relating to individuals in the last few weeks of life, the Department’s guidance is that if an individual had capacity to consent to the arrangements for their care/treatment at the time of their admission or at a time before losing capacity, and did consent, the Department considers this consent to cover the period until death and that hence there is no deprivation of liberty.

30. An important exception would be if the care package to which the individual consented were to change in a manner that imposed significant extra restrictions or which included care contrary to the previously expressed wishes and preferences of the individual. In such circumstances, the individual’s consent is unlikely to cover the changed care and an application for a DoLS authorisation or a Court of Protection order may be required if there is or will be a deprivation of liberty.

31. Where an individual lacks capacity and there is no valid consent, it must be remembered that there will be no deprivation of liberty unless the Supreme Court judgment “acid test” is met.

32. For this purpose it may be useful to bear in mind that, just because an individual is physically unable to leave their place of care/ treatment, this does not necessarily mean the individual is “not free to leave” under the acid test. Rather, the question is, would they be allowed to leave if they were assisted to do so e.g. by family/friends? If the provider would facilitate the person leaving, then the individual is not deprived of their liberty.

33. The Department has heard of one example of a Best Interest Asssessor being instructed to assess an individual in the final hours of life. Clearly this can be highly distressing for the individual and their family. We would urge local authorities, providers and DoLS professionals to consider carefully and use their professional judgment as to whether a DoLS assessment in such a situation is appropriate and adds any benefit to the individual concerned.

Transporting individuals

34. The Department believes it would be very rare for there to be a deprivation of liberty when transporting a patient in an ambulance or another vehicle for the purposes of care and treatment. Restrictions imposed while transporting a person who lacks capacity would nearly always be covered by the MCA.

35. However, providers should seek legal advice and potentially legal authorisation in respect of a particularly long journey to which the individual objects and during which significant restraints and restrictions are in place.

Deprivation of liberty in "community settings"

36. The DoLS scheme can be used to assess and authorise deprivations of liberty in care home, hospice and hospital settings. However, a "deprivation of liberty" that is "attributable to the state" can occur in other "community settings". This includes supported living arrangements and domestic settings. In these settings, the DoLS scheme is not available and instead, an application must be made to the Court of Protection.

37. Following the Supreme Court judgment, the Court of Protection launched a new streamlined procedure in November 2014 with a view to dealing with an increased demand for such applications. This is known as the "Re X procedure" and is supported by a new Court of Protection application form and a new practice direction[5]. The number of applications made under the Re X procedure to-date has been lower than expected.

38. The Court of Appeal cast doubt on the Re X procedure[6]. Yet a recent ruling by Justice Charles in the Court or Protection has potentially indicated a way forward for the Re X procedure. While appreciating the frustration of providers and local authorities, the Department's guidance is that applications should continue to be submitted to the Court of Protection following the Re X procedure where appropriate (and using the Re X forms).

39. The responsibility remains with those funding care in community settings (predominantly local authorities and clinical commissioning groups) to ensure they have a procedure and policy in place for identifying those individuals who may lack capacity and be subject to a deprivation of liberty. As with the wider response to the Supreme Court judgment, a response based on the MCA principles and which necessarily prioritises those individuals who stand to benefit most from this scrutiny of their care arrangements is advisable.

Coroners' inquests

40. The death of a person subject to a DoLS authorisation is legally classified as a death in "state detention". Such deaths must be reported to, and investigated by, a coroner under the Coroners and Justice Act 2009.

41. The Chief Coroner has issued guidance to coroners on this matter. This can be found at the link below.http://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf

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[5] ReX Court of Protection Application Form:

http://hmctsformfinder.justice.gov.uk/courtfinder/forms/cop-dol10-eng.pdf?utm_source=Newsletters&utm_campaign=b59bb46eae-MCL_November_2014_copy_01_11_17_2014&utm_medium=email&utm_term=0_0dd23690b2-b59bb46eae-117005089

[6] *Re X (Court of Protection Procedure)* [2015] EWCA Civ 599, http://www.bailii.org/ew/cases/EWCA/Civ/2015/599.html

42. The Coroners and Justice Act 2009 was passed by Parliament before the Supreme Court judgment and at a time when the concept of a "deprivation of liberty" was thought to be less common in health and care settings than is now the case. Following the Supreme Court judgment and the ten-fold increase in DoLS applications, the number of DoLS-related coroners' inquests has increased.

43. The Chief Coroner has noted that the inquest in question could be a "paper" inquest, without a jury and without a post-mortem examination. In a recent letter to senior coroners, the Chief Coroner has noted that some coroners have developed practical arrangements along the following lines:

    - Senior coroner meets or corresponds with the local authority, care homes, GPs, hospitals and hospices in a coordinated approach in order to explain that all DoLS deaths must be reported to the coroner (and why). Special reporting forms can be created or standard reporting forms amended.

    - Where a relevant death is reported to the coroner, the coroner's officer makes enquiries of the family about any concerns about the death, and if there are none, fast-tracks the investigation.

    - If there are no concerns and the death is from natural causes, the coroner will commence the investigation and release the body early.

    - The coroner's officer will obtain a copy of the DoLS authorisation, a statement of identification, the Medical Certificate of Cause of Death (if available) or the doctor's brief report of the cause of death, the referral form from the care home or hospital (if there is one) and brief circumstances of the death.

    - With this paperwork and if the family agree, the coroner will proceed to a paper inquest using Rule 23. If possible, the inquest can be listed within seven days, perhaps opening and closing at the same hearing. Families will not usually wish to attend.

44. The Chief Coroner notes that different considerations will, of course, apply if a post-mortem examination is required or the death may not be from natural causes

45. The Department of Health recognises the current law. We are grateful to the Chief Coroner for providing clarity and guidance in this area.

46. As DoLS practitioners will be aware, the legal concept of a "state detention" does not, in the great majority of cases, reflect the viewpoint of the family of someone who has died while subject to a DoLS authorisation. To them, the situation was simply one of normal care or treatment and any restrictions on liberty (to the extent they were perceived at all) were those necessary to care for their relative.

47. It is not surprising then that the Department has received reports of relatives who have become greatly distressed when informed that their relative died whilst "deprived of their liberty in state detention". And reports of relatives who have had their grief compounded when arrangements for funerals have been cancelled at short notice when an inquest has been launched.

48. A lot of this potential distress can be avoided through good communication with the family concerned, particularly stressing that:

    - The DoLS authorisation itself does not cause a deprivation of liberty. Rather it is the nature of the care and treatment being provided to an individual that results in a deprivation of liberty. DoLS are a safeguard and a positive tool in that they provide independent scrutiny to ensure that such a situation is in the best interests of the individual concerned. A "deprivation of liberty" can be an entirely appropriate result of providing an individual with good quality care. DoLS exists to ensure that is the case.

    - In the event of a death under DoLS, the instigation of a coroner's investigation does not imply any suspicion of foul play. Rather it is an additional safeguard that can provide reassurance to the family of the deceased. Following the Supreme Court judgment this practice will become much more common – relatives may find this knowledge reassuring.

49. Rapid and clear communication with the family is vital. Delays in informing the family that a coroner's investigation will take place are likely to increase any potential distress. Simple, clear information in written form as to what a coroner's investigation involves and with basic facts about DoLS would certainly be helpful.

50. The Department strongly supports the suggestion of the Chief Coroner that local organisations concerned (coroners, local authorities, care homes, hospitals, hospices and GPs) meet to draw up a co-ordinated approach. The involvement of local police would also be helpful. The Department has heard reports of uniformed police offices visiting the relatives of a deceased individual in an out-of-hours situation to begin investigations. This can cause considerable distress (although police practices vary throughout the country and sometimes these reflect long-standing local arrangements).

51. There are particular cultural sensitivities in some communities where quick burial or disposal of the body of the deceased is important. These issues are not new but clearly they may become more prevalent following the increase in requests for DoLS authorisations. It will be important that the co-ordinated approach local teams establish pay particular attention to these needs.

Best Interest Assessors operating in Wales

52. A few local authorities have asked whether Best Interest Assessors (BIAs) trained and registered in England, are able to perform best interest assessments for an English local authority that has placed an individual for whom they have responsibility into accommodation in Wales. The Department believes there is no block to this happening.

Approach to assessing requests for DoLS authorisations where an individual's circumstances have changed

53. In the current situation, it is clear that in some cases, by the time the local authority can consider a DoLS application, the individual's circumstances may have significantly changed. For example, they may have left the care home or hospital in question.

54. Clearly it is in no-one's interests to process paperwork for no good reason, especially when demand on the DoLS system is high.

55. Local authorities will wish to close off these DoLS applications in an appropriate and resource-efficient manner. This could be done by refusing the request and recording the reasons (i.e. because the request no longer reflects the individual's circumstances) or asking the relevant care home or hospital to withdraw the request.

56. Local authorities will want to be alert to where the individual in question is now resident. If the individual is living in a different location but a DoLS authorisation may still be required, local authorities may wish to prioritise their consideration of a new request – else the person in question may be in risk of an extended period of time without the independent scrutiny of DoLS.

Appointment of a Relevant Persons Representative (RPR)

57. Queries have been raised as to who, in the event there is no appropriate family member or friend, may be appointed as a RPR. The relevant regulations covering this can be found here: http://webarchive.nationalarchives.gov.uk/20100407222006/http://www.opsi.gov.uk/si/si2008/uksi_20081315_en_1

58. In short, the RPR could be an Independent Mental Capacity Advocate (IMCA) but it does not have to be. It could be a different form of advocate, an independent social worker or anyone that satisfies the regulations above. Many local authorities are seeking to diversify the range and type of person used to undertake the RPR role.

Notification of the RPR following the death of an individual

59. A couple of correspondents have asked whether the appointed Relevant Person's Representative (RPR) should be notified that a DoLS authorisation is no longer in place, following the death of the individual subject to a DoLS.

60. Clearly this would appear an unnecessary step and the Department's guidance is that there is no statutory basis for this requirement.

Appropriate expertise for mental capacity assessments

61. A couple of practitioners have asked whether individuals with particularly complex mental health disorders should have their mental capacity assessment undertaken by a professional with the relevant specific expertise. For example, an old age psychiatrist or a professional with expertise in complex learning disabilities.

62. The qualifying criteria for professionals conducting DoLS assessments are clearly described in legislation and in the DoLS Code of Practice. Clearly, local authorities will want to assure themselves that should DoLS assessors require expert support or input then this is available to them. Ensuring the quality of the DoLS assessment is important.

63. However, the Department also recognises that with the significantly increased number of DoLS applications, local authorities will also wish to ensure applications are not unnecessarily delayed.

64. Ultimately, the Department believes local authorities, working with providers, are best placed to make this judgment.

Implications of the "AJ" judgment

65. The judgment in the case of AJ[7] in February 2015 has caused considerable discussion. The judgment contained many helpful pointers for DoLS practitioners.

66. This included: the need to plan ahead in making standard authorisations wherever possible; and the need to be alert to admissions to care ostensibly for respite but where the underlying plan is for a permanent placement.

67. The judgment noted the importance of Relevant Person's Representatives (RPRs) being able and willing to maintain contact with the individual, represent and support the individual. The judgment also stated that it would be "*difficult for a close relative or friend who believes that it is in P's best interests to move into residential care, and has been actively involved in arranging such a move, into a placement that involves a deprivation of*

[7] *In re AJ (Deprivation Of Liberty: Safeguards)* [2015] EWCOP 5, http://www.bailii.org/ew/cases/EWCOP/2015/5.html

liberty, to fulfil the functions of RPR, which involve making a challenge to any authorisation of that deprivation".

68. Finally, the judgment noted that the appointment of an RPR (or IMCA) "*does not absolve the local authority from responsibility for ensuring that P's Article 5 rights are respected* [and that] *in circumstances where a RPR and an IMCA have failed to take sufficient steps to challenge the authorisation, the local authority should consider bringing the matter before the court itself*".

69. Local authority DoLS teams have raised their concerns as to the potential resource implications of this Court of Protection judgment. The Department would advise that local authorities and providers take steps to ensure their DoLS protocols and procedures are reviewed to ensure they take account of the principles described in this judgment – much as they would with any new case law. But clearly local authorities and providers will want to ensure that their budgets are deployed to maximise benefits for service users.

<u>Data submissions to HSCIC</u>

70. A few queries have been recently raised regarding the submission of DoLS data to the Health and Social Care Information Centre (HSCIC).

71. Following the Supreme Court judgment, the DH and ADASS co-chaired Data and Outcomes Board commissioned a quarterly collection of aggregate DoLS data on a voluntary basis from LAs over a period of 18 months. This enabled a national picture of the impact of the Supreme Court judgment to be built. This quarter, July-September 2015, is the last of the planned voluntary collections and has transferred from HSCIC to DH. There are no changes to the content of the collection. This data will be published on 3rd November 2015.

72. The mandatory annual DoLS data collection will of course continue. We are aware that with the increased number of DoLS applications, queries have been raised in regard to some of the data fields. The HSCIC runs a regular working group that local authority colleagues charged with completing the data submission can join to raise their questions and concerns. If you would like to find out more about this, please contact Luke Thickins at the HSCIC (luke.thickins@hscic.gov.uk).

Further sources of guidance

73. The Department commissioned the Law Society to produce guidance for practitioners on what constitutes a deprivation of liberty following the Supreme Court judgment. It contains advice by different health and care setting and useful "key questions" sheets that can help identify a potential deprivation of liberty. This can be found at the following link: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

74. Professionals will want to read this guidance in light of the proportionate, person-centred approach to the Supreme Court judgment advocated by the Department. Professionals will want to consider the benefit to the individual and tailor their response appropriately.

Annex – Examples of actions taken by partners in response to the Supreme Court judgment

NB. This list is supplied is response to requests for more information as to approaches taken elsewhere in the country. The Department does not comment on the relative value of each – clearly partners will want to determine the approach best suited to their context.

<u>BIAs</u>

- Expectation that all experienced social workers undertake BIA training and then be available to do a minimum number of best interest assessments per month
- Extra BIAs recruited, to a new dedicated BIA team
- BIA qualification an expected part of career progression
- BIA qualification linked to pay scales and pay progression
- A dedicated BIA recruited specifically to focus on supported living settings
- Joining with other local authorities to buy BIA training places at reduced cost
- Dedicated team of BIAs working on a rota basis. 10 in total, at any one time 5 in the dedicated DoLS team and 5 dispersed elsewhere – helps disperse knowledge
- Maximum £300 fee for independent BIAs
- Agreement to joint fund with local CCG, BIA training for nurses

<u>Engagement with partners</u>

- An initiatives for raising awareness with GPs
- Close working with commissioners (inc. NHS) to identify priority individuals
- Coroner has written to all GPs – proactive in communicating the issues and need for a proportionate and pragmatic response
- BIAs and DoLS team attending care home forums to boost awareness and answer questions
- Hotline set up to respond to questions from providers & partners
- Maximising value from mental health assessors: asking them to assess their own patients for free/ preventing "double charging", booking a doctor for a day for multiple assessments, capping per assessment payments
- Council sponsored seminar for all local partners and interested organisations
- Multi-agency task and finish groups to design and agree shared protocols – with legal support
- Close work with CQC inspectors to promote a shared view and understanding of the impact of the Supreme Court's judgment.

<u>Dealing with the volume of DoLS applications</u>

- Taking special care to prioritise cases where objection present
- Grading applications as they arrive – prioritising
- Reviewing backlog regularly to identify cases that may have moved up the priority list
- Regular Monday morning call-round of providers to determine likely applications to be submitted as well as priority status of applications waiting to be processed
- ADASS priority tool being used and having positive effect
- Continual focus on quality (more important than simply meeting timescales)
- Contact centre staff have been briefed on DoLS and provided with basic information and

tips on where to redirect callers to other sources of information
- Scoping exercise of community settings and prioritising applications for the Court of Protection
- Increased pool of available signatories – senior staff training
- Team restructured to ensure admin work taken from BIAs and performed by admin/ support staff
- Care home appointed an "MCA champion" who could clearly explain benefit of DoLS to families and the individual
- Dedicated "case co-ordinator" who works solely to ensure conditions placed on DoLS authorisations are being adhered to

<u>Boosting basic MCA awareness</u>

- Local NHS has instigated an MCA Champions programme for reaching out to professionals and providing advice on capacity assessments
- MCA Floor-walkers, provide assistance on capacity assessments and on basic recording
- Using DoLS to increase NHS understanding of restrictive care and addressing so called "voluntary placements" that are in fact a non-capacitated deprivation of liberty
- Important to continue work to sensitise professionals, the individual and families to the potential need for a DoLS application during the care assessment and planning process

<u>New tools/ practices</u>

- Coloured form placed on front of care plan held by managing authorities detailing status of DoLS application – allows rapid identification by staff and particularly useful at mitigating confusion as to whether a DoLS has been applied for/ is in place. Also, negates confusion in event of death – allows GP for example to immediately spot if a coroner's referral is required
- Established a check-list for deciding if an RPR can be a family member (in light of AJ ruling)
- DASS have delegated sign-off of "simpler"DoLS authorisations – quicker turnaround. Perform occasional quality checks
- New ADASS forms resulting in better quality BIA assessments
- Data spreadsheet tweaked to better correspond to HSCIC return and speed up data submission
- Regular papers and updates for LA senior management and also to committee of elected members
- Delirious patients – important to allow some time to see of situation resolves and capacity returns
- Informal meetings with RPRs to explain requirements of the role to them
- Using DoLS assessments to help identify safeguarding issues
- Basic information leaflet for relatives explaining DoLS, preparing one for relatives of deceased subject to a coroner's inquest
- Internal staff trained to deliver training to others – allows greater training provision at better value for money.