Adult Services and Wellbeing

Calderdale Metropolitan Borough Council

Standard Operating Procedure (SOP):

Community DoLS

**Standard Operating Procedure Community Deprivation of Liberty Safeguards**

**Contents**

## **1 Overview 4 - 17**

## **Mental Capacity Act and deprivation of Liberty 4**

##  **Restraint 4**

## **Statutory Context 5**

## **Deprivation of Liberty in Different Settings 7**

1. **Objectives of Court of Protection Deprivation of Liberty 8**

**Authorisations**

## **Cross References and Legislation 9**

## **Safeguarding Considerations 9**

1. **Case Recording 12**
2. **Information Sharing 14**
3. **Finance, financial implication and assessment. 15**
4. **Process and Procedures 17 - 23**
5. **Routes into the Process for both new and Renewal Authorisations 17**
6. **Considerations Prior to Making the Application 18**
7. **The Referral and Screening Process 19**
8. **Waiting safe and Well Process 19**
9. **Completing the Application to the Court of Protection 20**
10. **Completing the forms 21**
11. **Once the Court order authorising the Deprivation of Liberty has 23**

 **been received**

1. **Process Outcomes 23**

**APPENDICES 34 - 43**

1. **Community DoLS Referral Form 1X 35**
2. **Calderdale Re X Priority Tool 39**
3. **Community DoLS Forms List 43**

 **Procedure Version Control**

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| --- | --- |
| **Procedure Name** | **Standard Operating Procedure: Community DoLS**  |
| **Document Description** | **This Standard Operating Procedure sets out the Community DoLS aims, objectives and underlying principles together with consistent ways of working.**  |
| **Document Owner** | Anne Flanagan |
| **Document Author** | Annette Wilby | **Date** | August 2024 |
| **Status** | Live | **Version** | 2.0 |
| **Last Reviewed** | March 2025 | **Next Review Date** | March 2026 |
| **Approved by**  | Anne Flanagan | **Position** | Assistant Director ASW |
| **Signed** |  | **Date Approved** | March 2025 |

|  |
| --- |
| **Document Change History** |
| **Version Number** | **Date** | **Amendments** |
| 1.0 | August 2024 | New Document |
| 2.0 | March 2025 | Updated the new safeguarding process  |
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**Standard Operating Procedure Community Deprivation of Liberty Safeguards**

## **1 Overview**

1. **Mental Capacity Act and Deprivation of Liberty**

The Mental Capacity Act 2005 (MCA) provides a statutory framework for people who lack capacity to make decisions or take actions for themselves. Therefore, others may be required to make those decisions on the person’s behalf. This should not deprive the person who lacks capacity of their liberty, unless it is essential to do so in the person’s best interests and for their own safety.

The Deprivation of Liberty Safeguards (DoLS) were introduced by the Mental Capacity Act 2005 to prevent the unlawful detention of adults in hospital and care home settings whereby the person is unable to give informed consent to their residence, for the purpose of their care and treatment. DoLS provides a framework for authorising the deprivation of liberty who lack the capacity to consent to necessary treatment in hospital or care home. This is authorised buy a Best Interest Assessor (BIA). (Please see DoLS SOP).

Community Deprivation of Liberty Safeguards follow the same framework, however the process and authorisation within a community setting differs from that of a ‘DoLS scheme DoLS’ by means of requiring a judge via the Court of Protection (COP), to authorise the deprivation of liberty rather than a BIA.

1. **Restraint**

 A person is using restraint if they:

* Use force, or threaten to use force, to make someone do something that they are resisting, or
* Restrict a person’s freedom of movement, whether they are resisting or not

Restraint is appropriate when it is used to prevent harm to the person who lacks capacity, and it is a proportionate response to the likelihood and seriousness of harm.

Appropriate use of restraint may fall short of deprivation of liberty.

The duration of any restrictions is a relevant factor when considering whether a person is deprived of their liberty. If restraint or restriction is frequent, cumulative, and ongoing, then care providers should consider whether this goes beyond permissible restraint and DoLS authorisation is required.

Although appropriate restraint may lawfully be used under the MCA, it should be seen as an indicator that a person’s wishes **may** be being over-ridden. In these circumstances the person may be being deprived of their liberty and authorisation is needed.

In the case of a person in hospital for mental health treatment, the need for restraint is likely to indicate that they are objecting to treatment or to being in hospital.

A person who objects to mental health treatment is **ineligible** for an authorisation under the deprivation of liberty safeguards. If it is necessary to detain them, use of the Mental Health Act 1983 should be considered.

[Promoting less restrictive practice: reducing restrictions tool for practitioners | Local Government Association](https://www.local.gov.uk/publications/promoting-less-restrictive-practice-reducing-restrictions-tool-practitioners)

## **Statutory Context**

**What is a Deprivation of Liberty and Why Does it Exist?**

**In October 2004, the European Court of Human Rights (ECtHR) announced its judgment in the case of HL v the United Kingdom (commonly referred to as the ‘Bournewood’ judgment).**

**HL was a profoundly autistic man with a learning disability, who lacked the capacity to consent to, or to refuse, admission to hospital for treatment. The ECtHR held that he was deprived of his liberty when he was admitted, informally, to Bournewood Hospital.**

**The ECtHR further held that:**

**• the manner in which HL was deprived of liberty was not in accordance with ‘a procedure prescribed by law’ and was, therefore, in breach of Article 5(1) of the European Convention on Human Rights (ECHR), and**

**• there had been a contravention of Article 5(4) of the ECHR because HL was not able to apply to a court quickly to see if the deprivation of liberty was lawful.**

**To prevent further similar breaches of the ECHR, the MCA 2005 has been amended to provide additional safeguards for people who lack mental capacity and whose care or treatment necessarily involves a deprivation of liberty within the meaning of Article 5 of the ECHR, but who either are not, or cannot be, detained under the Mental Health Act 1983.**

**These safeguards are referred to as “deprivation of liberty safeguards.” Deprivation of Liberty Safeguards were enacted in 2007 and came into force in 2009.**

**Extracts from the Bournewood judgment**

**‘… to determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.’**

**‘The key factor in the present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements’**

**‘The applicant was under continuous supervision and control and was not free to leave’.**

**Cheshire West**

**In March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”.**

**The Supreme Court confirmed that to determine whether a person is objectively deprived of their liberty there are two key questions to ask, which is described as the ‘acid test’:**

1. **Is the person subject to continuous supervision and control? (all three aspects are necessary) and**
2. **Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave – are they required to return?).**

**This now means that if a person who does not have the mental capacity to consent to their situation is under what can be said to be continuous supervision and control and they are not free to leave, then they are very likely to be deprived of their liberty.**

**A deprivation of liberty for such a person must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation under the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005 or by a Court of Law – namely an Order made by the Court of Protection.**

**In order to establish whether deprivation of liberty is taking place, it is necessary to consider all the circumstances of each case. It is not possible to say that any single factor alone would always or could never amount to a deprivation of liberty.**

**Some of the factors and questions asked by a Best Interests Assessor for DoLS are relevant when considering whether a person might be Deprived of their Liberty in a Community setting - these include -**

 **What measures are being taken?**

 **When are they required?**

 **For what period will they endure?**

 **What are the effects of any restraint or restrictions?**

 **Why are they necessary?**

 **What aim do they seek to meet?**

 **What are the views, wishes, and feelings of the person?**

 **What are the views of the person’s family or carers?**

 **How are any restraints or restrictions to be applied?**

 **Do they go beyond restraint & restriction and become deprivation of liberty?**

 **Are their less restrictive options available?**

 **Does the cumulative effect of the restrictions amount to deprivation of liberty even though individually they would not?**

***Note that this is not an exhaustive list*.**

**An authorisation only relates to deprivation of liberty and does not, for example, give authority for any individual act of care or course of treatment. Evidence of the proper application of the Mental Capacity Act is what provides protection from liability for professionals and carers who are planning or providing any acts of care that are restrictive.**

1. **Deprivation of Liberty in different settings**

**Deprivation of Liberty in Care Home:**

Authorised by Best Interest Assessor. (*A care home is specified as a registered care home by CQC and includes some respite placements. Please note, if the care provision and the property are provided by the* ***same*** *company, this is classed as a care home*).

Maximum length of authorisation = 12 months.

**Deprivation of Liberty in Hospitals:**

Authorised by Best Interest Assessor. (*Hospitals are registered on CQC and can include NHS, independent and community hospitals*).

Maximum length of authorisation = 12 months.

**Deprivation of Liberty in the Community:**

Application made by appointed worker, \*must be a registered professional practitioner such as social worker, nurse, occupational therapist etc. (*Community settings include all other settings, not limited to person’s own home, supported living, supported accommodation and extra care*).

Maximum length of authorisation = 12 months.

There are 2 different ways that these applications and proceedings can happen

1. Direct Application for full Court Proceedings and hearings (please see the Court of Protection – Welfare Proceedings SOP, and the Policy Portal Court of Protection Section for further details.
2. A paper-based application where all the relevant documents are sent to the Court and to a nominated judge, but without any proceedings or hearings. This is a streamlined approach to Court Authorised DoLS that evolved out of a specific Court Case after the huge increase in applications since the Cheshire West (2014) ruling, The Court Case was called “Re X” and so this streamlined, and paper-based approach is often called a **“Re. X” application**. This approach is only an option for specific, stable and uncontroversial situations where the person not being a party to the proceedings would cause no detriment to them. (pls see further information on this in the Considerations prior to making an application section below).

## **Objectives of Court of Protection Deprivation of Liberty Authorisations**

**Ordinary Residence and Safeguards:**

That all individuals who are Ordinary Residents of Calderdale (whether they are residing within Calderdale or not) have the benefit of the safeguards to their Article 5 right to Liberty that a Court Authorised Deprivation of Liberty application and Order provides.

This includes

-independent review of their care and residence by a Judge in the Court of Protection

-the ability to access Independent Mental Capacity Advocate Support for the person and potentially their family/representative.

- the appointment of a representative for the person for the duration of the Authorisation (known as the Rule 1.2 Representative) – either a family member or friend, a paid advocate, or a Court Appointed Visitor

- The ability of the person to request to be made a “party to the proceedings” -i.e. be able to participate in a full hearing and speak with the judge themselves.

- The ability to obtain Authority (alongside the COP DoLS process) from the Court of Protection for CMBC to sign a tenancy agreement on the behalf of the person, where there is no one else with the legal authority to do so. This will provide the person with increased rights and protections as a formal tenant.

1. **Cross References and Legislation:**
* Mental Capacity Act 2005
* Mental Capacity Act 2005 Code of Practice
* Mental Capacity (Deprivation of Liberty) Regulations 2008
* Deprivation of Liberty Safeguards - Code of Practice 2008
* Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative) Regulations 2008
* Mental Health Act 1983 and Mental Health Act 2007
* Care Act 2014
* [Care and Support Statutory Guidance: Section 10 (Care and Support Planning)](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)
* CMBC Mental Capacity Act 2005 Policy (LINK)
* CMBC Deprivation of Liberty Standard Operating Procedure (Link)
* The Law Society: Identifying a Deprivation of Liberty

<http://www.lawsociety.org.uk/Support-services/documents/Deprivation-of-liberty---a-practical-guide/>

* LGA / ADASS Promoting Less Restrictive Practice: Reducing Restrictions Tool (April 2024). <https://www.local.gov.uk/publications/promoting-less-restrictive-practice-reducing-restrictions-tool-practitioners#:~:text=This%20tool%20aims%20to%20help%20practitioners%20identify%20restrictions%20in%20a>
* [a-basic-guide-to-the-court-of-protection-july-2020-3.pdf (courtofprotectionhandbook.com)](https://courtofprotectionhandbook.com/wp-content/uploads/2020/07/a-basic-guide-to-the-court-of-protection-july-2020-3.pdf)
* Policy Portal Mental Capacity Act Resources <https://www.calderdaleappp.co.uk/appp-mentalcapacity/>
1. **Safeguarding Concerns, Notification, Initial and Screening and Processing**

 **Overview***:* Stage 1 involves the identification and reporting of safeguarding concerns before the Safeguarding Adults Practitioners engage with the person at risk or experiencing abuse or neglect.

Practitioners will be mindful of S42 of the Care Act 2014, identifying where there may be a cause for concern that someone with possible care and support needs, in their area may be at risk of or experiencing harm or neglect and unable to protect themselves. This includes but is not limited to; physical abuse, emotional and psychological abuse, financial abuse, sexual abuse, coercive controlling behavior, and self-neglect.

Practitioners will have a responsibility for accurately identifying concerns, the source, type of harm, impact of harm/potential harm and urgency of the concern. Practitioners should consider and follow the Calderdale Threshold Guidance for Safeguarding Adults at Risk prior to raising a concern.

If practitioners are actively involved with a person whereby concern or information is shared, whether factually supported or not, they will make enquiries to ascertain that the person is safe and well and ascertain what action needs to be taken and what legal framework this may be under. This includes considering if this requires raising as a statutory safeguarding concern. This should be led by the person with Making Safeguarding Personal (MSP) underpinning the approach. Capacity to consent to safeguarding concerns should be considered at the point a potential safeguarding concern is identified, ensuring that the person is supported to engage with and understand what this means. In the event a person is deemed to lack capacity to consent, consideration should be given for involving a relevant representative and/or referring for an advocate. Only in circumstances where there is an immediate risk to the person and/or to the safety of another person should consent not be sought prior to raising a safeguarding concern.

Practitioners will formally report a safeguarding concern by completing the standard Calderdale Safeguarding Raising a Concern form and submitting this electronically to Gateway to Care via email. If any social care practitioner (with access to CIS) identifies the concern they will be responsible for completing respective safeguarding stage one screens on CIS.

Practitioners retain a responsibility to promoting the welfare and safeguarding children and young people (s11, Children’s Act 2004) also. If information comes to the attention of a worker that a child or young person may be experiencing or at risk of harm or neglect, they will share this information with Children’s services within a timely manner. This may be by contacting Multi Agency Screening Team (MAST) or sharing information with an allocated children’s worker or team.

#### **How to Raise a Safeguarding Concern**

**During Office Hours**

* **General Public and Professionals**: Concerns can be reported by anyone in accordance with the guidance and consideration to The Threshold Guidance for Adults at Risk in Calderdale. Reports can be made via:
* **Safeguarding Concern Form**: Complete and submit the form to gatewaytocare@calderdale.gov.uk .
* **Telephone**: Call Gateway to Care at 01422 393000.
* **Safeguarding Adult Team Contact Details:**
* **Telephone (Duty):** 01422 393375
* **Email:** safeguarding.adults@calderdale.gov.uk
* **Specific Agencies**:
* **Police, Yorkshire Ambulance Service**: These agencies may use their own forms to notify **safeguarding concerns.** These forms are accepted as valid notifications or referrals.
* **Calderdale & Huddersfield Foundation Trust**: Will submit concerns where the abuse or neglect occurred within a hospital setting to the Hospital Discharge Team. It is likely that the Hospital Discharge Team will give cause to the Hospital to make the safeguarding enquiries, with the Hospital Discharge Team acting as co-ordinators.

**Out of Office Hours**:

* + **Emergency Duty Team (EDT)**: For concerns raised outside standard office hours (5:00 PM to 8:45 AM Monday to Thursday and 4:30 PM to 8:45 AM Friday to Monday), contact the EDT at 01422 288000. The EDT will assess the concern, take necessary immediate actions to address immediate and imminent risks (that cannot safely wait until the next working day), and notify Gateway to Care on the next working day.

### **Notification, initial screening and processing**

**Gateway to Care Responsibilities**:

* **Electronic Concerns. Inputting into CIS**: Upon receipt, Gateway to Care will promptly check whether or not the person has a CIS record. Gateway to Care will create a record if there isn’t one. Gateway to Care will then forward the electronic form on email to the Safeguarding Adults Team mailbox or (for people with a primary support reason around mental health) go direct to the Mental Health Team mailbox (on outlook) and case note the action they have taken.
* **Telephone Concerns**: People who telephone asking to raise a safeguarding concern or if the social care advisor identifies that there is a possible safeguarding concern, they should first discuss this with the Duty Social Worker, Team Leader or Team Manager, before progressing with creating the concern on CIS. Once advice has been sought the Social Care Advisor can progress with creating the concern on CIS, completing the necessary fields and gathering as much information as possible from the person raising the concern. They then assign this on CIS to the Safeguarding Adult Team or the Mental Health Team (if primary support reason is for mental health) and follow this up with an email to the respective mailbox to alert them of the concern on CIS.
* **No Initial Decision Making**: At this stage, no decisions are made regarding the concern other than recording it on the appropriate person's record and assigning to the relevant team. Information gathering is minimal and only to address any critical missing details necessary for record creation.

**Hospital Team Responsibilities**:

* The Hospital Discharge Team is responsible for receiving any concerns where the abuse or neglect occurred within a Calderdale and Huddersfield Hospital setting. The Hospital Discharge Team is responsible for inputting the concerns on to Safeguarding Adult Stage 1 screens on CIS. The Hospital Discharge Team can give cause to the Hospital Safeguarding Team to undertake the enquiries, however the Hospital Discharge Team retains responsibility for co-ordinating the enquiry and updating CIS as per the processes described below.

**Safeguarding Adult Team, Mental Health Team and Hospital Discharge Team Responsibilities**:

* **Receipt of the concern**: The Team Manager, Team Leader or Practice Lead will receive the incoming concern on outlook (or CIS if initial concern is taken via the phone).
* **Initial Screening:** Decide whether the concern falls within the scope of safeguarding: The Team Manager, Team Leader or Practice Lead will review the information contained within the concern and decide whether or not it falls within the scope of safeguarding. The main question to ask at this stage is whether or not abuse or neglect is occurring that may require safeguarding enquiries. The three-stage test is not applied at this point.

If the concern is around a ‘request for support’ (for people who do not have any ongoing care and support in place) or a ‘review of support’ (for people who do have ongoing care and support in place), then this can be forwarded to the relevant team i.e. Gateway for people who do not have care and support in place or community teams for those who do. If the person subject to the concern has an allocated worker, then they need to be notified. Similarly, complaints (quality or practice issues relating to care providers) can be forwarded to community teams to consider and liaise and resolve and if required copy in ICCQT.

* If the Manager, Team Leader or Practice Lead decides that the initial concern **does** fall within safeguarding then the Safeguarding Adult Team or Mental Health Team need to input the concern on to CIS as a stage one and associate any documents. They then allocate it to a Safeguarding Practitioner within their respective team.
* If the Manager, Team Leader or Practice Lead decides that the initial concern **is not** safeguarding they need to associate records to file and document actions taken on a case note.

## **Case Recording**

***Case recording is an essential part of daily social work practice. It involves:***

* recording the views of the adult and their carers.
* writing down the work that has been undertaken.
* life history, assessment and analysis.
* documenting the progress adults make towards their desired outcomes.

Case recording also provides an evidence trail of the work done with an adult, and their carer and is a vital tool to enable staff to reflect on their ongoing work with adults / carers and plan future work. Records should be used as part of supervision, in conjunction with their supervisors / managers.

Staff should always remember that in the event of a safeguarding enquiry or other investigation, case records will be used and ccommodati. Staff will be held accountable for all entries they make and should be mindful of this when documenting their actions and professional judgements.

Staff should also remember that records may be shared with the adult, and this should be reflected in the language used and the manner in which judgements are recorded

**Case records should:**

* be based on a general principle of openness and accuracy:
* be drawn up in partnership with the adult.
* record the views of the adult, in their own words where appropriate, including whether they have given permission to share information.
* be an accurate and up to date record of work, which is regularly reviewed and summarised.
* include a record of decisions taken and reasons for them.
* include a chronology of significant events.
* be evidence based and ethical.
* separate fact from opinion.
* incorporate assessment, including a risk assessment where appropriate
* include an up-to-date care and support plan
* record race / ethnicity, gender, religion, language and disability
* be used by the supervisor / line manager as part of overall measurement of staff performance
* include management sign off where appropriate
* be kept securely and shared in accordance with data protection principles (see Data and Protection Act 2018)

***In addition to ensuring the principles above underpin case recording, other areas to consider include:***

* the adult’s voice should not be ‘missing’ from the case record: whilst actions taken in relation to them are documented, their wishes, feelings, views and understanding of their situation should be clearly recorded. There may be a tendency to focus on the views of a carer who is able to be more vocal, rather than the adult who may have more difficulty in expressing themselves
* the size of the record may make it difficult to manage records should be focused and important information highlighted, and regular summaries /transfer summaries included to make it easier to find for others reading the record
* a completed assessment should be on file: information must be analysed, and a plan created for the assessment to be complete. An assessment is not just about collating information
* the record must be written for sharing: making it easy for the adult to read and understand. Language should be plain, clear and respectful, keeping social work terms and abbreviations / acronyms to a minimum. Records should be shared regularly with the adult to encourage them to contribute to the record
* the record should be used as a tool for analysis: it should not simply record what is happening, but also to analyse and hypothesise why particular situations and events are occurring. The use of genograms, chronologies and assessment records can help organise and analyse information.
1. **Information Sharing**

Information sharing is a critical component of providing effective and coordinated care. Adhering to these procedures ensure that information is shared appropriately, respecting confidentiality and legal requirements while promoting the well-being of individuals receiving care and support.

***Purpose and Necessity***

* **Define the Purpose:** Clearly identify the reason for sharing information, ensuring it is relevant and necessary for the individual’s care and support.
* **Assess Necessity:** Determine if sharing information is essential to provide care, protect individuals, or comply with legal obligations.

***Consent and Involvement***

* **Obtain Consent:** Seek explicit consent from the individual to share their information, ensuring they understand what will be shared, with whom, and why.
* **Informed Decisions:** Provide individuals with sufficient information to make informed decisions about their consent.
* **Document Consent:** Record the consent given, noting any conditions or preferences expressed by the individual.
* **Lack of Consent:** In situations where consent cannot be obtained, information may still be shared if it is necessary to protect the individual or others from harm (e.g., safeguarding concerns).

***Confidentiality and Data Protection***

* **Respect Confidentiality:** Ensure that information shared is kept confidential and shared only with those who have a legitimate need to know.
* **Data Protection Laws:** Comply with data protection laws, such as the General Data Protection Regulation (GDPR), which governs how personal information should be handled and shared.

***Information Accuracy and Relevance***

* **Ensure Accuracy:** Verify that the information to be shared is accurate, up-to-date, and relevant to the intended purpose.
* **Limit Sharing:** Share only the information necessary to achieve the intended purpose, avoiding the disclosure of excessive or irrelevant details.

### **Finance, financial implication and assessment.**

### **Early Financial Information**

***Objective:*** To ensure that people are informed about the financial implications of their care at the earliest opportunity, allowing them to make well-informed decisions about whether or not to received social care services.

***Process:***

* **Initial Contact:** At the initial contact (duty) stage or upon allocation of a Social Worker, initiate an upfront discussion about the potential financial implications of care services. This early conversation helps manage expectations and ensures that individuals are aware of any financial impact.
* **Financial Information Pack:** The allocated Social Worker is responsible for sending out the financial information pack to the person. This pack should be provided preferably before any home visit, either via email or post based on the person’s preference. The pack contains crucial information about potential care costs and can be accessed online via the calculator: [Care Charge Calculator](https://new.calderdale.gov.uk/dio/care-charge-calculator).

***Documentation:***

* Ensure that a record is made in the Client Information System (CIS) that the financial information pack has been sent and received.

### **Confirmation of Receipt and Financial Information**

**Objective:** To confirm that the person has received the financial information and understands the implications of the financial assessment process.

***Process:***

* **Confirmation Form:** During the home visit, obtain signed confirmation from the person acknowledging receipt of the financial information pack. Use the form designed for this purpose, which also includes options to:
	+ Confirm if they do not wish to proceed with the financial assessment.
	+ Indicate if they exceed the capital limit and will therefore pay the full cost of care.
* **Legal Responsibility:** Verify that the person signing has the legal authority to do so, such as having Lasting Power of Attorney.
* **Uploading Documentation:** Upload the signed confirmation form to CIS and associate it with the person’s record.

***Documentation:***

* Ensure the signed confirmation form is accurately uploaded and linked to the person’s record in CIS.

### **Assisting with Financial Information Form (FIF)**

**Objective:** To support individuals in completing the Financial Information Form (FIF) and ensure timely submission for financial assessment.

***Process:***

* **Assistance Offer:** If the person is unable to complete the FIF themselves and has no support, offer assistance. Encourage self-service where possible or help them find a financial representative such as a family member or friend.
* **Providing Help:** If providing direct assistance, accept photos of bank statements, pension letters, etc., as evidence. Send these documents to Business Support for uploading after the visit.
* **Disability Related Expenditure (DRE):** Record any disability-related expenditure (DRE) in the conversation record, as stated in the Council’s charging policy. This ensures that any additional necessary expenditure due to a disability is accounted for in the financial assessment.

***Documentation:***

* Record any assistance provided and evidence gathered in CIS. Ensure that DRE is noted in the Living Well conversation record where applicable.

### **Financial Assessment Completion and Case Management**

**Objective:** To ensure that financial assessments are completed in a timely manner and that cases are managed effectively to avoid any delays in care planning.

***Process:***

* **Financial Assessment Monitoring:** Check case notes to confirm whether the financial assessment has been completed before closing a case. Ensure that all required financial information is provided within 5 weeks of starting to receive services.
* **Late Submission:** If financial information is not provided within the stipulated time, CAT (Charging Assessment Team) will notify the person that they will be assessed to pay the full cost of care due to non-compliance. Work collaboratively with CAT to resolve any delays in the financial assessment process.
* **Pre-Closure Check:** Before closing a case, verify in CIS that CAT has completed the financial assessment. If there is no record, contact CAT to determine the reason for any delay.

***Documentation:***

Maintain accurate records in CIS of all communications with CAT and any actions taken regarding the financial assessment. Ensure that financial assessments are completed before the 6-week review or before case closure.

## **2 Process and Procedures**

**NB: A Complete list of the Court of Protection DoLS Forms can be found in Appendix 3, all form templates are available in the Policy Portal Community DoLS section.**

### **Routes into the process for both new and renewal authorisations:**

**Contact from provider:** Referrals for new authorisations are primarily received by care providers making contact with either the person’s allocated social worker, the locality team or the MCA and DoLS team directly.

**Internal query:** Discussions regarding the potential of someone being deprived of their liberty can stem from any internal contact such as but not limited to; safeguarding, care management or Gateway to Care.

**Allocated case:** Social workers and adult social care practitioners are expected to consider if a person is deprived of their liberty when allocated to support an individual. This should be recognised and responded to appropriately to ensure people are not being deprived of their liberty without relevant safeguards in place.

**Reviewing: Care reviews offer an opportunity to consider if the person is being deprived of their liberty. This should be considered within all reviews and highlighted if there is a deprivation of liberty concerns.**

**Renewals:** All individuals who have previously had an authorisation in place should be monitored and documented in a way whereby renewals are able to be triggered and prioritised prior to the authorisation ending.

### **Considerations Prior to Making the Application**

***The following steps are likely to be needed in most social care cases before an application to the CoP is made:***

* An up-to-date Care Act assessment for the person concerned, including, where applicable, an analysis of risk and risk management plan.
* If the person has ‘significant difficulty’ in participating in the Care Act assessment, an ‘appropriate individual’ should be identified to represent them.
* Consideration of relevant advocacy (including Care Act advocate if no appropriate person can be found to assist the individual in a Care Act assessment).
* Clarity regarding which decisions are needed, who can make them, which options are available and will be funded and ensure that there is a best interest’s decision.
* Is there also a need to agree a tenancy agreement for a person who lacks the mental capacity to do so and has no-one legally appointed to act for them? Tenancy issues can also be raised during applications to authorise deprivation of liberty and there will be a benefit to the person and to the process by ensuring such requests are co-ordinated.

Many acts of care can be delivered, and many actions taken by reliance on Section 5 of the MCA where the person lacks mental capacity, and the action is in their best interests. Note that Section 6 MCA limits the use of restraint and specifies that it must be necessary to protect the person from harm and be a proportionate response to the likelihood and seriousness of the harm.

In an emergency a person may be deprived of their liberty by reliance on Section 4B MCA if it is necessary in order to give the person life-sustaining treatment or carry out vital acts (i.e. acts reasonably believed to be necessary to prevent a serious deterioration in the person’s condition). This can only be done after, or at the same time as an application is made to the Court of Protection.

**Triggers – May Not be ReX Suitable**

* Any contest by the relevant person, or anyone else involved.
* Not meeting the six assessment criteria.
* Failure to consult with the relevant person and others.
* Any objection from the relevant person.
* For if any other reason the Court or Rule 1.2 Representative think an oral hearing is required.

### **The Referral and Screening Process**

**Form 1X: *Referral Form, to be completed by care provider or allocated worker.* (Appendix 1)**

**This form needs to be completed as fully as possible; it is designed to capture all necessary information to appropriately identify the level of restrictions in the person’s life. The information on this form will be used to screen and determine if there is a potential deprivation of liberty and prioritise the urgency of the referral.**

**DoLS ReX Screening and Priority Tool: *Completed by internal worker.* (Appendix 2)**

**This tool has been developed using the ADASS prioritisation tool and is used to consider information within the Form 1X. This tool will assist in prioritising a referral for a Community DoLS into either:**

* **Urgent**
* **High**
* **Medium**
* **Lower**
* **Refer to Care Management**

**Following this screening and prioritising taking place, an acknowledgment letter should be sent to the person, provider and family if required and appropriate, regarding the outcome of the screening. As per ‘Waiting safe and well process’, direct contact information will be shared. Alongside this, a request will be made for the provider or family member to contact the relevant team to update of any changes in circumstances. All documentation should be uploaded to CIS. The track and trigger system such as a specific Excel spreadsheet should be completed with the individual’s details and their priority rating.**

**A discussion will be had with supervisor or manager regarding what cases will be allocated dependent upon priority.**

**The spreadsheet will be reviewed regularly by management and priority cases considered within allocation processes.**

### **Waiting Safe and Well Process**

***Contact and Communication:***

People awaiting assessment are given clear instructions on how to contact the relevant service. Once a potential deprivation of liberty has been identified through any of the aforementioned routes, a request will be made for a referral Form 1x to be completed. This will be screened and prioritised. An acknowledgement letter informing of priority rating given, alongside a standard "Waiting Well" letter is issued, detailing interim support and contact information.

* 1. **Completing the Application to the Court of Protection**

**Once a case has been identified and allocated to a worker there are a number of forms that require completion. Some of these forms need to be completed by external parties.**

**Actions and Considerations:**

**Contact CMBC Adult Legal: Contact should be made with our inhouse legal team to open a case file. Your named legal worker will support the allocated worker through the process and ensure all documents are suitable to be sent to the Courts. Please ensure each document is sent once completed as your legal worker may request some amendments if required.**

**Currently, CMBC Adult Legal Services can be contacted via**  **ahsclegal@calderdale.gov.uk** **in the first instance.**

**A named worker in the legal team will be provided to you to work directly with on the application.**

**Form 4X: This needs to be completed by a medical professional, that of a Section 12a doctor or psychiatrist. Allocated worker will contact** MCA.DoLSGroup@calderdale.gov.uk **and request a Form 4x to be completed. Once a Section 12a doctor has been identified they will visit the person nd complete the form to evidence if the person has a mental disorder.**

**Identify a Rule 1.2 Representative: Discuss with the person, family or friends if anyone is able and wiling to complete the Rule 1.2 Representative role. If there is no one appropriate or wiling to complete this role, a Spot Purchase referral will be made to Cloverleaf Advocacy. (Further information below).**

**Care Plan: The Court require a copy of the person’s care plan form the provider. This needs to include the persons care and a summary of the restrictions in place. Contact will be made to the provider informing them this needs to have been reviewed within the last 3 months and to include a front cover. The front cover should include Tile of ‘Person’s name’ Care Plan, a photograph of the person, the persons address, and should be hand signed and dated when the care plan was last reviewed.**

**Tenancy Agreement:Ascertain if the person has a signed tenancy agreement and if this is signed correctly. Only an LPA, a Court Appointed Deputy or a person named on a previous Court Order is able to sing a tenancy agreement on behalf of the person if they lack capacity to sign themselves. If there is no one appropriate to sign on the behalf of a person who cannot, following a mental capacity assessment determining the person is unable to sign a tenancy agreement, the worker can request in the application for the Local Authority to sign on the persons behalf. Include a copy of the tenancy agreement within the Court bundle if required.**

 **Any Previous Court Order: Consider any previous orders and send a copy within the application bundle.**

**Any Advanced Decisions or Lasting Power of Attorney: You will need to be aware of this to ensure the ‘no refusals’ assessment is completed whereby the authorisation cannot conflict with any advanced decision made by the person or with any decision made by LPA or a Court Appointed Deputy.**

**The Application Fee: CMBC Legal colleagues will administrate this. An appropriate budget code will need to be identified for every application - i.e. which area/ team will be responsible for authorising the payment.**

* 1. **Completing the forms:**

**CoP 3 Form:** ***Completed by the allocated worker.***

This is the Mental Capacity Assessment Court form. The decisions to be assessed are; If the person can:*Litigate, make decisions regarding their care needs, make decisions about where they should live,* and when required, *entering into a tenancy agreement****.***

 **Best Interest Form (with balance sheet): *Completed by the allocated worker.***

Consider the person’s wishes, is an IMCA required, what is the least restrictive to the person’s freedoms and consult with appropriate others. The balance sheet should be used to consider benefits and burdens of each option that would be available to the person. The balance sheet templates are available from the Policy Portal, MCA Section.

**CoP 11 Form:**

This is the main body of the application. The form first requests the relevant person’s personal details (filled in by the worker) and then separates into three sections called Annexes to be completed by different people

**These are:**

***Annex A*: *Completed by the allocated worker.***

This section of the CoP 11 Form requires for an explanation of why the proposed care-plan involves a deprivation of the liberty, why it is necessary and, in the person’s, best interests, and why it is the least restrictive option available. The form also has to explain how the deprivation of liberty is “imputable to the state”, meaning how state agencies (like the NHS or a local authority) are involved in the arrangements**.**

***Annex B: Completed by the allocated worker****.*

This section of the CoP 11 Form asks for confirmation that other people have been consulted according to the normal processes within the Mental Capacity Act regarding best interest decisions. The views of the people who have been consulted must be summarised (if necessary attaching separate statements). People who could have been consulted, but who have not been, e.g. other relatives, friends and carers who might have views on the application must also be documented in this section.

***Annex C: Completed by the Rule 1.2 Representative.***

This section of the CoP 11 Form requires confirmation that the person to whom the application relates has also been consulted about the application and what it means for them. Confirmation that the person has been told about their rights, including the right to ask to take a direct part in the Court’s decision-making will be included.

This should preferably be done by someone who knows the person and is able to express their views. This could be a relative or friend, for example, or someone the person has previously chosen to act on their behalf (e.g. someone they have given a lasting power of attorney).

Whoever completes Annex C must record the person’s views, wishes, and feelings about the application, and whether they have said they would like to make their views known directly to the court and, if so, whether they want to formally become a party to the case.

Any other documentation sent to the Court is done using a standard **CoP 24 Form -** Witness **Statement Template**. There are likely to be a number of these required within an application, namely:

* **CoP 24 Form: *Witness Statement, allocated worker.***

Your named legal worker may request the worker to include further information on a CoP 24 form. This should be written clearly with each paragraph numbered. If a Form 4x which is over 12 months old is being used, the worker will be requested to complete a witness statement regarding there being no changes in mental diagnosis, presentation and no concerns relating to the need for a further mental health assessment to be completed.

* **CoP 24 Form*: Witness Statement, Rule 1.2 Representative.***

A further Witness statement from the persons Rule 1.2 representative will be required confirming; *they are willing to act as the persons Rule 1.2 Representative*; *they have seen the Court of Protection Deprivation of Liberty application and supporting evidence; whether from the perspective of the persons best interest they agree the Court should authorise the residence and package of support;* and *that they agree an oral hearing is not required*.

Final versions of each form and document will be collated together within an email and sent to your named legal worker. This ‘bundle’ will be associated to the persons CIS file. Your named legal worker will update of any further information requested by the Court. Your named legal worker will share the order with the allocated worker once this has been received. (***Please note some example forms are available on the Policy Portal.)***

* 1. **Once the Court order authorising the Deprivation of Liberty has been received:**
* The order should be case noted and associated to CIS with a note on the front page informing there is a CoPDoL order in place and the Adults Social Care Legal Team should be contacted for advice prior to **any changes in residence or support as this will need to be brought to the attention of the Court.**
* The order should be shared with the person, provider, Rule 1.2 Representative and any other relevant people where appropriate.
* The tracking system (Currently an excel spreadsheet) should be updated and a **trigger reminder to review the person’s situation 9 months from the date the order was made with a view to a further application to the Court of Protection if a further Deprivation of Liberty Authorisation is still required.**
* Any significant change in the persons circumstances or situation will require a review and consultation with the Adults Social Care Legal Team.
	1. **Process Outcomes**
* All CMBC Adult Social Care employees have a responsibility to consider and recognise people who are deprived of their liberty.
* Developing further skills and confidence across Adult Social Care Teams in relation to identifying restrictions and deprivations of liberty. Also, in completing Mental Capacity Assessments and liaising with the Adult Social Care Legal Team.
* Transparency regarding how to screen, prioritise and allocate cases.
* Able to identify those who would benefit the most from the safeguards, such as those unbefriended.
* Any issues with the persons situation is identified and considered with a view to rectify as part of pre assessment work.
* Priority waiting list to be held, reviewed and actively managed by supervisors and managers, in line with ‘Waiting safe and well’.
* Transparency, with open lines of communication for and referral, waiting list and general queries.
* Any work, actions and outcomes are logged on CIS with relevant documents associated.

**Appendices**

|  |
| --- |
| **Community DoLS Referral Form – 1x****Appendix 1***Own home, family home, supported living, shared lives.* |
| Full name of person  |  | Sex |  |
| Date of Birth *(or estimated age if unknown)* |  | Est. Age |  |
| Relevant Medical History (*including diagnosis of mental disorder if known*) |
| Name and address of the service or person requesting this authorisation |  | Tel. No. |  |
| Person to contact to gather further information (may be the service provider or family member). | Name |  |
| Telephonenumber |  | Email address: |  |
| Usual address of the person, (if different to above) |  | Telephone Number |  |
| Name of the Local Authority where this form is being sent | CALDERDALE Metropolitan Borough Council |
| How the care is funded | *Please Specify* | Local Authority [ ]  |
| NHS | [ ]   | Local Authority and NHS (jointly funded) | [ ]   |
| Self-funded by person | [ ]   | Funded through insurance or other | [ ]   |
| Have appropriate family members, friends, or others named by the relevant person, been informed about this COP DoLS application? *If no, please explain:* | Yes[ ]  | No[ ]  |
| **Please complete the following questions and include as much detail as possible.****PLEASE READ GUIDANCE UNDER QUESTION.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Yes** | **No** | **Further information** |
| Do you think the person **lacks** the mental capacity to consent to their accommodation and/or care package?*Please detail what steps you took to enable the person to make the decision.**Does the person understand where they live and why, what support they receive and why. Does the person understand the risks posed to them for if they were to decline support?* | [ ]  | [ ]  |  |
| Is the person likely to be prevented from leaving the service without permission?*If the person sought to leave or someone sought to support the person to leave their home/service, would they be prevented from doing so? It does not matter if the person is not objecting, what would happen if they did?* | [ ]  | [ ]  |  |
| If the person was to leave without permission, would they be located and returned to the service?*If yes, who would do this?* | [ ]  | [ ]  |  |
| Does it appear the person subject to continuous supervision and control?*Do staff members/family know where the person is and what they are likely to be doing at any given time? The person does not need to be in sight at all times, are their whereabouts always known?*  | [ ]  | [ ]  |  |
| Is the person subject to any restriction on contact with family/friends?*Please describe fully how and why this happens.**Is there a court order in place? Or an order via the police? What are the persons wishes and feelings regarding contact?* | [ ]  | [ ]  |  |
| Is the person objecting to their accommodation/treatment?*This can simply be a person saying they don’t want to be there, or they want to be somewhere else. Please consider the persons presentation and body language, do they try to leave, do they stand near the door, do they decline coming home or express behaviours in which may be an objection. Please describe.* | [ ]  | [ ]  |  |
| Is any other person objecting to the placement/ccommodation e.g., family/friend/professional or any other contentious issue?*For example, is there a disagreement between some family members as to what care should be provided and where? Has someone shared they do not feel current placement is in persons best interests?* | [ ]  | [ ]  |  |
| Is the person subject to **any** physical/mechanical restraint or seclusion?*This can include medication to sedate, bed rails, lap belts, head guards, mittens, physical restraint at times etc.**Please indicate of any assistive technology used such as bed alarms/sensors, door sensors, locking systems, GPS tracking systems, cctv.* | [ ]  | [ ]  |  |
| Is the person subject to any other specific risks or restrictions?*If ‘Yes’, please provide further details e.g., is it high, medium, or low.* | [ ]  | [ ]  |  |
| Is there any person(s) who are legally appointed to make decisions on behalf of the person, or has the person made any advanced decisions?*Court appointed depute, Lasting Power of Attorney, please give details.* | [ ]  | [ ]  |  |

|  |
| --- |
| **Care and Treatment** – Please give a day-to-day picture of support the person receives and highlight any restrictions the individual is subject to*Summarise the care and / or treatment this person is receiving or will receive day-to-day.* *Please indicate tasks and level of support / intervention required and an explanation of WHY this support is in place.* *-What would the risk be without the support? What risks remain?**-What restrictions are in place – do you think they are proportionate?* |
| **Domain** | **Details of care and treatment, including any restrictions** |
| **Communication and sensory**.*How is the person supported to communicate. Are there any communicative aids or strategies in place to promote effective communication. Does the person require hearing aids, glasses etc?* | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions:*** |
| **Eating and drinking**.*What level and type of support is required in relation to managing and maintaining nutrition. What support is required re cooking/eating/drinking. Does the person decide what they would like to eat. Any health input form SALTs etc.* | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions:*** |
| **Personal care***What support does individual require re personal care needs, do they object –how is this dealt with. What level of support is required. Consider shaving. Any continence issues/use of incontinence pads. Extra equipment or staff required for safe moving and handling.*  | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions:*** |
| **Health and healthcare.***Is support required to attend medical appointments, what level of support is required. Any health team involvement such as epilepsy nurse, LD Health. Support required to take medication – any aids such as dosset box or pivotel.* ***Please include Medication list including PRN – how often and PRN protocol.*** ***NOTE you can attach this as a copy if required.*** | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions:**** **Medication List** -*Full medication list*
* **PRN** – *detail. How often, in what circumstances, is there a PRN protocol in place*?
* **Covert Medication**? – *details*
 |
| **Living environment and finances***What level of support is required for person to manage home environment. Does person have access to all personal items. Does person require support to manage finances – what does this look like, is there an appointee in place.**What were the persons living arrangements prior to the placement?**How long have they lived here?* | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions*** |
| **Family and social life.***Does the person require support to maintain contact with family members and access social activities. What does this support look like. Does the person have any restrictions on contacting any other person. Is electronic communication utilised?* | ***Summary:**** ***Does the person have friends and family?***
* ***Please specify if visits are in person or by telephone/video call?***

***Level of support required: (1:1, 2:1, prompts, direct support*) – How often is the family contact?*****Risks:******Restrictions:*** |
| **Accessing community and privacy**.*Is support required for person to access community, what level of support is required. Does the person have access to a key, can they use this independently. Are they able to use public transport? Does person require mobility aids?* | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions*** |
| **General/personal** *Is the person being supported by appropriately trained staff? Is the person able to dress and wear what they would like, are they able to identify as they like. Does the person have any religious or cultural needs, how are these considered?* | ***Summary:******Level of support required: (1:1, 2:1, prompts, direct support*)*****Risks:******Restrictions*** |
| Any further information relating to care and support or restrictions.**Tenancy information**  | **Weekly 1:1/2:1 Support hours:****Night-time support:****Does the person have a signed tenancy agreement?****Who has signed this?** |

|  |
| --- |
| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** |
| ***Family member or friends contact details.*** | Name |  |
| Address |  |
| Telephone |  |
| ***Would above family member or friend be able/happy to support named person as a representative******throughout COP DoL process? If so, do they communicate and visit the person regularly?*** *Pease specify if face to face contact is had and how regularly.* |
| ***Anyone named by the person as someone to be consulted about their welfare*** | Name |  |
| Address |  |
| Telephone |  |
| ***Anyone else engaged in caring for the person or interested in their welfare*** | Name |  |
| Address |  |
| Telephone |  |
| ***Any named Lasting Power of Attorney granted by the person*** | Name |  |
| Address |  |
| Telephone |  |
| **Any Personal Welfare Deputy appointed for the person by the Court of Protection** | Name |  |
| Address |  |
| Telephone |  |
| **Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005**  | Name |  |
| Address |  |
| Telephone |  |

|  |
| --- |
| **THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)** |
| Yes |  | No |  | *If* ***Yes*** *please describe further e.g. application/order/direction, community treatment order, guardianship* |
|  |
| **OTHER RELEVANT INFORMATION** |
| Names and contact numbers of regular visitors not detailed elsewhere on this form:  |
| Any other relevant information including **safeguarding** **issues**: |
| **PLEASE NOW SIGN AND DATE THIS FORM**  |
| Signature  |  | Print Name |  |
| Date |  | Time |  |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A COP DoLS AUTHORISATION** *(Please sign to confirm)* |  |

NOTE: This is not the end of the form, please continue.

|  |
| --- |
| **RACIAL, ETHNIC OR NATIONAL ORIGIN** *Place a cross in one box only* |
| White |  | Mixed / Multiple Ethnic groups |  |
| Asian / Asian British |  | Black / Black British |  |
| Not Stated |  | Undeclared / Not Known |  |
| Other Ethnic Origin *(please state)* |  |
| **THE PERSON’S SEXUAL ORIENTATION** *Place a cross in one box only*  |
| Heterosexual |  | Homosexual |  |
| Bisexual |  | Undeclared |  |
| Not Known |  |  |
| **OTHER DISABILITY** *While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.**To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of “other disability” may be unrelated to an assessment of mental disorder or lack of capacity. Place a cross in one box only* |
| Physical Disability: Hearing Impairment |  | Physical Disability: Visual Impairment |  |
| Physical Disability: Dual Sensory Loss |  | Physical Disability: Other |  |
| Mental Health needs: Dementia |  | Mental Health needs: Other |  |
| Learning Disability |  | Other Disability (none of the above) |  |
| No Disability |  |  |  |
| **RELIGION OR BELIEF***Place a cross in one box only* |
| None |  | Not stated |  |
| Buddhist |  | Hindu |  |
| Jewish |  | Muslim |  |
| Sikh |  | Any other religion |  |
| Christian (includes Church of Wales, Catholic, Protestant and all other Christian denominations) |  |

 **Calderdale Re X DoLS Priority Tool**

**Appendix 2**

**A Screening tool to prioritise the allocation of “Re X Cases” to apply to the Court to authorise a deprivation of liberty.**

**This screening tool is an indicative guide only as it will generally be based on information provided by the Managing Authority in the application and each case must be judged on its own facts. In addition, it would be good practice to screen any waiting list for length of wait as well as geographical location. Councils may have further support tools within each of the categories.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **URGENT** | **HIGHER** | **MEDIUM** | **LOWER** | **REFER TO CARE MGT.** |
| A situation where it appears the individual urgently needs the safeguards that Re X DoLs will bring. | A situation which appears to meet the acid test and requires the safeguards to ensure more substantive protection. | A situation which technically meets the acid test and requires the safeguards but there are some actions which can be taken in the short term, in the persons best interests, to manage the impact of the arrangements.  | A situation which technically meets the acid test and requires the safeguards but there is no evidence to suggest there will be any substantive changes.  | A situation where there are wider issues to be addressed before any applications to the Court can be considered. A situation that does not appear eligible for a Re X application. |
|  | **Factors to consider in each category** |  |
| * The individual is unbefriended.
* There are ongoing issues, concerns, or restrictions upon family relationships that in effect cause an individual to have no support or representative.
* Any other legal issues or factors eg applications for deputyship.
 | * Sedation/psychotropic medication is used frequently, regular use of PRN to control behaviour.
* Covert medication.
* Physical restraint is used regularly – equipment or person.
* Restrictions on family/friend contact (or other significant Article 8 issue) – that doesn’t in effect cause an individual to have no support or representative.
* High level of supervision (1:1. 2:1 etc)
* Any periods of confinement or segregation.
 | * **Appears to be unsettled some of the time but staff have measures in place to redirect, reassure or to distract which are effective, in the short term.**
* **Psychotropic medication is prescribed for regular use (non-covert).**
* **Infrequent use of PRN or restraint.**
* Appears to meet some, but not all of the aspects of the Acid test (excluding capacity)
 | * Minimal impact on the person, or evidence of continuous supervision and control.
* No evidence of specific restraint or restrictions being used but rather a general sense of supervision and control such as expected in the setting.
* End of life situations, which may meet the acid test but there will be no benefit to the person from the Safeguards.
* Has been living in the place for a number of years and appears to happy and thriving – the support and residence appears to be providing a positive and fulfilled life.
 | * Any objections or unhappiness expressed by the individual to their living circumstances.
* Any objections expressed by any family member or interested party to the individual’s living circumstances.
* Any situation where there is an apparent need for reassessment and review.
 |
| **Renewals or further Authorisations** |
| Councils vary in their ability to keep upto renewed applications to the Court. The screening process will identify whether the need is a new one or for a renewal, but the priority that each renewal will require will be made subject to an assessment of the risks and needs of each particular case. The fact there is a known Deprivation of Liberty is acknowledged.  |
| **Safeguarding History** |
| The safeguarding history for the induvial will be considered and factored into the screening process |
| **Referrals into Case Management**  |
| Following the Re X DoLS Screening process, it may become apparent that Case Management work appears to be required with the individual. In such cases, a referral will be made to the appropriate Care Management Team. Information from the screening process will be shared with the team in order to assist them with their own prioritisation of work. Cases where such referrals have been made will cease to be included/prioritised within the Re X waiting list. |
|

|  |  |
| --- | --- |
| **Name:** | **CIS:** |
| **Date:** |  | **Prioritised by:** |  |
| **Summary:** | XXXXX **does not** / **appears to meet** the acid test criteria:* Continuous supervision,
* Not free to leave,
* Lacks capacity to give informed consent to residence for purpose of receiving care and treatment.

**Level of restrictions,** *give details** 1:1 / 2:1:
* Night support:
* Equipment, assistive technology, sensor mats, movement, sound or video monitoring:
* Physical restraint:
* Bed rails, belts or straps, hoists, harness, mittens, headguards:
* Locked doors or cupboards, confinement to an area:

**Family contact.*** Has regular family contact?
* Is Unbefriended?
* Has restrictions on family contact?

 Any evidence of objection from **XXXX** or interested parties? **Yes/no.** *details:***Medication*** Any covert medication? **Yes/no** d*etails:*
* PRN? D*etails:*
* Psychotropic medication? *Medication list*

**Any open referrals?****Previous COP DOL order?****Safeguarding concerns?****Tenancy details?** *Unsigned/Signed, by who?***LPA/Deputy/Advanced decisions?****Health Funding:**  |
| **Allocated priority*****Mark with an X*** |  **URGENT [ ]**  | **HIGHER** **[ ]**  | **MEDIUM [ ]**  | **LOWER [ ]**  | **REFERRAL [ ]**  |

 |

**Appendix 3**

|  |
| --- |
|  **Community DoLS Forms**  |
| **Name of Form**  | **Description** | **Who might Use this?**  | **Where can a template be accessed?** |
| Form 1X | Referral and notification form regarding a potential Community DoL | Care Provider, Social Worker or Service Co ordinator | Policy Portal -CoP DoL section |
| Form 4X | COP DoL version of a DoLS Form 4 to obtain clinical evidence the person has a mental disorder  | G.P, sec. 12 approved Dr (accessed via the DoLS team)  | Policy Portal -CoP DoL section |
| Form 11X | COP DoL version of the DoLS Form 11 IMCA referral | Allocated Worker | Policy Portal -CoP DoL section |
| COP 3 | Court of Protection Capacity Assessment Form | Allocated Worker | Policy Portal -CoP DoL section |
| COP 11 | Main Application form for a COP DoL Authorisation without a full hearing or proceedings | Allocated Worker, IMCA, Rule 1.2 Rep. | Policy Portal -CoP DoL section |
| COP 24 | Court of Protection Statement template - for any purpose/ written information outside of the standard COP DoLS forms | Allocated Worker, IMCA, Rule 1.2 Rep. | Policy Portal -CoP DoL section |
| Rule 1.2 Rep Referral | Referral to the Advocacy Service for a Rule 1.2 Rep | Allocated Worker | Policy Portal -CoP DoL section |
| Best Interests | Best Interests decision record form – either meeting or form | Allocated Worker | Policy Portal – MCA section |