

## DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) POLICY (for adults 18 years and older)

		POLICY
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<b>Author (Position &amp; Name)</b>	Julie Spizer, MCA Lead Nurse	
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**CONTENTS**

<b>Item</b>	<b>Title</b>	<b>Page</b>
1.0	INTRODUCTION	3
2.0	POLICY STATEMENT	4
3.0	DEFINITIONS/ ABBREVIATIONS	4-6
4.0	ROLES AND RESPONSIBILITIES	7-10
5.0	APPROVAL	10
6.0	DOCUMENT REQUIREMENTS (POLICY NARRATIVE)	10-17
	6.1 What is a Deprivation of Liberty?	10
	6.2 Does the Mental Health Act 1983 Apply?	11
	6.3 Identifying Possible Deprivation of Liberty	12
	6.4 Identifying the Managing Authority and Supervisory Body	13
	6.5 Urgent Authorisations	14
	6.6 Review: Form 10	14
	6.7 The Relevant Person's Representative	15
	6.8 The Assessment under Deprivation of Liberty Safeguards	15
	6.9 Continuation of Deprivation of Liberty Safeguards	16
	6.10 Discharge	16
	6.11 Death of a DoLs Patient	16
7.0	MONITORING COMPLIANCE AND EFFECTIVENESS	18
8.0	TRAINING AND IMPLEMENTATION	19
9.0	IMPACT ASSESSMENTS	20
10.0	EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS	20-24
11.0	KEYWORDS	25
12.0	APPENDICES	25
<a href="#">Appendix 1</a>	Deprivation of Liberty Safeguards Flowchart	26-27
<a href="#">Appendix 3</a>	Equality Impact Assessment Proforma	28-29

## 1.0 INTRODUCTION

'This policy is issued and maintained by the Chief Nurse (the sponsor) on behalf of the trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.'

The Deprivation of Liberty Safeguards (DoLS) provides legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights (ECHR) in a hospital or care home. This occurs whether placed under public or private arrangements. These safeguards provide a proper legal process and suitable protection in circumstances where a deprivation of Liberty appears to be unavoidable, is in a person's own best interest and where it is the least restrictive alternative. DoLS do not apply to people detained under the Mental Health Act 1983.

DoLS was introduced in response to the 2004 'Bournewood judgment' in the European Court of Human Rights. This case was brought by carers of an autistic man who was kept at Bournewood Hospital against their wishes. The Court found that the circumstances by which the patient was admitted and kept in hospital breached the human right to liberty (Article 5(1) European Convention of Human Rights Deprivation of liberty) and also of Article 5(4), the right to have the lawfulness of detention reviewed by a court.

Use of the DoLS authorisation can avoid similar breaches of human rights and provides protection for people:

- Who lack the mental capacity specifically to consent to treatment and care in either a hospital or care home

### And

- The care can only be provided in circumstances that amount to a deprivation of liberty;
- The care is in their best interests to protect them from harm;
- Detention under the Mental Health Act 1983 is not appropriate for the person at that time

On the 19 March 2014 the Supreme Court delivered its judgment in the cases of P and Q and Cheshire West which has had a significant impact in relation to deciding which legal framework is used to admit and provide care and/or treatment for individuals who may lack the capacity to consent to their admission, care and treatment in hospitals and care homes.

The new working definition of 'Deprivation of Liberty' must now be applied and the use of any other definition or the exercise of any personal or professional discretion is highly likely to be unlawful.

Staff should view this policy as supplementary to the statutory Mental Capacity Act Code of Practice and the DoLS Code of Practice. Both Codes of Practice are available on the Safeguarding Adults intranet site and also on the Department of Health website:

[www.dh.gov.uk](http://www.dh.gov.uk)

## 2.0 POLICY STATEMENT

The purpose of this policy is to provide staff working within Sherwood Forest Hospitals NHS Foundation Trust with guidance about the Deprivation of Liberty Safeguards.

Including:

- To set out the main provisions of the Mental Capacity Act
- To Identify the duties placed on staff
- To provide a procedure to determine the circumstances in which the various processes described within the Deprivation of Liberty Safeguards should be followed. This includes processes for:
  - The clinical and administrative application of the Deprivation of Liberty Safeguards
  - The monitoring of the clinical and administrative application of the Deprivation of Liberty Safeguards
  - Supporting those applying or monitoring the Deprivation of Liberty Safeguards

This clinical policy applies to:

### Staff group(s)

- All clinical staff working within ED, EAU, Outpatients and adult in-patients, young people aged 16-17 years with impaired mental capacity (e.g. doctors, nurses, allied health professionals)

### Clinical area(s)

- All adult in-patient clinical areas at all hospital sites (KMH,MCH&NH)

### Patient group(s)

- It applies to all patients with impaired mental capacity that are over 18 years and older (Including women under the care of the maternity services) and for whom care or treatment is given in circumstances that might amount to Deprivation of Liberty.

### Exclusions

- Children and young people up to 18 years of age
- Patients sectioned under the Mental Health Act.

## 3.0 DEFINITIONS/ ABBREVIATIONS

'The Trust':	Means the Sherwood Forest Hospitals NHS Foundation Trust
'Staff':	Means all employees of the trust including those managed by a third party organisation on behalf of the Trust.
Deprivation of Liberty	The term used in Article 5 of the European Convention of Human Rights which states, that everyone has the right to liberty and it can be taken away in certain circumstances and only if legal processes are used. It is also the term used if the Court of Protection authorises detention of a person outside of a care home or hospital. It is sometimes referred to by the acronym DoL (rather than DoLS).
Deprivation of Liberty Safeguards	The legislation in England and Wales (part of the Mental Capacity Act 2005) that provides the procedures and rules governing a deprivation of liberty in care homes and hospital.

Consent	Consent is the voluntary and continuing permission of a patient to be admitted to hospital and/or given a particular treatment, based on sufficient knowledge of the purpose, likely effect and risk of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. Patients who lack capacity to consent cannot consent. Compliant acceptance of any intervention, including admission to hospital is not consent.
Restraint	The Mental Capacity Act 2005 affords protection to health and social care staff who are obliged to use restraint to provide care or treatment to adults who lack capacity and who would be at risk of harm if they did not receive the necessary care or treatment. Under the Mental Capacity Act, health care staff will be protected from liability when applying restraint in these circumstances, as long as the restraint is necessary to prevent the incapacitated person from coming to harm, it is proportionate to the likelihood and seriousness of that harm, and the degree of restraint applied does not amount to a deprivation of the persons liberty.
Capacity	Mental capacity is always referred to as time and situation specific. Where the term 'lack of capacity' is used throughout this document it refers specifically to the capacity to decide whether or not they wish to be accommodated by the Trust (whether temporarily or permanently) and whether they consent to the proposed care and/or treatment that involves circumstances that amount to deprivation of liberty when that decision needs to be made.
Managing Authority	Under the Deprivation of Liberty Safeguards the term Managing Authority refers to any hospitals or care homes that are registered with the Care Quality Commission.  Throughout this policy the term Managing Authority refers to Sherwood Forest Hospital NHS Foundation Trust.
Supervisory Body	Supervisory Bodies are those organisations that commission and authorise the Deprivation of Liberty Safeguards. For the purpose of this policy the Supervisory Bodies are locality specific and refer to the local authority of which a person is usually a resident. This can vary, staff are to check to ensure the referral is sent to the correct local authority to ensure no 'breaches' occur.
Care Quality Commission (CQC)	The inspectorate body for care homes and hospitals in England. It has specific responsibility for monitoring DoLS.
Breach	Depriving a person of their freedom may breach a person's human right to liberty Article 5 (1) European Convention of Human Rights and Article 5(4), the right to have the lawfulness of detention reviewed by a court. The safeguards protect people who lack the ability to make certain decisions for themselves and ensure their freedom is not inappropriately restricted.
Standard Authorisation	An authorisation given by the Supervisory Body after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.

Urgent Authorisation	An authorisation given by a Managing Authority for a maximum of seven days, which may be extended by a maximum of a further seven days by a Supervisory Body. The Urgent Authorisation gives the Managing Authority lawful authority to deprive a person of their liberty whilst the standard authorisation process is undertaken.
Code of Practice	This refers to the Deprivation of Liberty Safeguards Code of Practice which supplements the main Mental Capacity Act 2005 Code of Practice.
Best Interest Assessor (BIA)	The Best Interest Assessor is a specially trained professional who is responsible for conducting a range of assessments to ascertain whether an authorisation for deprivation of liberty should be granted. The Best Interest Assessor is appointed by the Supervisory Body.
Approved Mental Health Professional (AMHP)	A health or social care professional who is approved to undertake assessments under the Mental Health Act 1983. Many AMHPs are also BIA qualified and can undertake certain assessments under DoLS.
Mental Health Assessor	The Mental Health Assessor is a Section 12 Approved Doctor or a Registered Medical Practitioner (with at least 3 years post registration experience in the diagnosis or treatment of mental disorder) who has completed the necessary Mental Health Assessor training. The purpose of the mental health assessment is to ensure that the person suffers from a mental disorder as defined by the Mental Health Act 1983 (any disorder or disability of the mind) in order to ensure that the deprivation is in accordance with Article 5 of the European Convention on Human Rights which require the individual in these circumstances to be of 'unsound mind'.
Independent Mental Capacity Advocate (IMCA)	This is someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. An IMCA is not the same as an ordinary advocate. The IMCA service was established by the Mental Capacity Act 2005.
Relevant Person	Is the person who is made subject to an Urgent and/or Standard Authorisation under the Deprivation of Liberty process.
Relevant Person's Representative	The role of the Representative is to maintain contact with the Relevant Person, support that person and represent that person in matters relating to the Deprivation of Liberty Safeguards. The Relevant Persons Representative may be a family member or appropriate carer. If no such person is available or forthcoming then the Supervisory Body may appoint a paid representative.
Court of Protection	The court that governs the Mental Capacity Act including DoLS. It can make decisions regarding a person's mental capacity and what is in their best interests.
Association of Directors of Adult Social Services (ADASS)	The Association of Directors of Adult Social Services (ADASS) is a charity and representative body for all directors of adult social services in England. It was registered as a charity in 1987 under the name the Association of Directors of Social Services. It aims to promote the provision of high quality social care to all those who need it.

#### 4.0 ROLES AND RESPONSIBILITIES

Title	Role	Key Responsibilities
All Trust Staff	Adherence	<ul style="list-style-type: none"> <li>- Ensure all people who are using our services are treated with Dignity and respect and those individuals and their families/carers receive appropriate care and support</li> <li>- Apply the key principles and pay due regard to the Codes of Practice (Mental Capacity Act and DoLS)</li> <li>- Ensure they know the legal status of the patients they care for/ treat</li> <li>- Ensure they know where to locate policies and procedures when necessary</li> <li>- Adhere to all Trust policies and procedures</li> <li>- Identify and escalate any potential deprivation of liberty</li> <li>- Maintain good, accurate, timely records</li> <li>- Ensure care plans reflect the patient past wishes, and note involvement of the unpaid representatives/IMCA</li> <li>- Adhere to any conditions attached to the Deprivation of Liberty Safeguards Authorisation imposed by the Supervisory body in their care delivery</li> <li>- Ensure records are made to a good standard and record decisions around care delivery</li> <li>- Monitor and regularly review patient's capacity in respect to their care</li> <li>- Ensure MDT meetings demonstrate in nursing notes the regular discussion of the patient's Legal status and capacity</li> <li>- Keep themselves informed of legal developments that may have a bearing on their practice. The Mental Capacity Act Trust intranet site will be updated on case law and changes in developments and staff should also access other research material and information</li> </ul>
Community Staff	Adherence	<ul style="list-style-type: none"> <li>- Safeguard their patients, in respect to the Deprivation of Liberty's</li> <li>- Ensure they are alert and able to identify any potential deprivation of liberty</li> <li>- Ensure the manager in charge of the person's care in the care setting is informed of any community staff concerns that a deprivation of liberty may be taking place and enquire if there is a legal provision for this</li> <li>- Remind patients of their legal obligations if there is no identified legal provision in place. If this continues to occur then community staff must complete a safeguarding alert</li> </ul>

Title	Role	Key Responsibilities
Ward Leaders, Matrons and all Clinicians	Implementation	<ul style="list-style-type: none"> <li>- Ensure that care is delivered in the least restrictive way and is proportionate and necessary to prevent harm</li> <li>- Ensure that the ward processes are in place to review and update patient care plans and consider the patient's ability to consent and be actively involved in their care planning</li> <li>- Ensure that no person is deprived of their liberty except where legally permitted through an urgent or standard application through a DoL or through detention under the MHA 1983 (as amended 2015)</li> <li>- Ensure their staff are informed of the Deprivation of Liberty Safeguards and receive sufficient training and support to undertake their role</li> <li>- Ensure that when a patient is identified as being deprived of their liberty the appropriate documentation is completed and submit an application to the Supervisory Body</li> <li>- Take all steps to minimise the restrictions imposed on a person</li> <li>- Where there are concerns that appropriate care and treatment is likely to result in a DoL they should: <ul style="list-style-type: none"> <li>▪ Inform the Responsible clinician of their concerns, and actions to be addressed/ discussed, urgently</li> <li>▪ Escalate concerns if a consensus cannot be reached</li> <li>▪ Apply for an urgent authorisation for a DoL to commence before a standard authorisation can be obtained</li> <li>▪ Notify the appropriate persons if an application has been made</li> <li>▪ Ensure all relevant staff involved in the patient care are informed of the DoL and any authorisation, and that should circumstances change the MDT must be notified</li> <li>▪ Ensure the relevant person and their unpaid representative understand the effects of an authorisation once it is granted and that they understand their rights for appeal</li> <li>▪ Ensure that all documentation encompasses the above</li> <li>▪ Make alternative arrangements for care where a DoLS authorisation has been refused</li> <li>▪ Inform the Responsible clinician, the mental capacity Lead and staff where a DoLS has been refused and the reasons why (see also dispute MHA /MCA )</li> <li>▪ Inform the MCA Lead via <a href="mailto:sfh-tr.safeguardingadults@nhs.net">sfh-tr.safeguardingadults@nhs.net</a> when applications are made to the supervisory body, and when authorisations are granted by the Supervisory Body</li> </ul> </li> </ul>



Title	Role	Key Responsibilities
		<ul style="list-style-type: none"> <li>▪ Ensure the Database is updated to ensure that the MCA lead can monitor compliance and any potential breaches</li> <li>▪ Have local methods of identifying the legal status of a patient on their ward</li> <li>▪ Ensure all staff are keeping records of the amount of contact between the representative and the relevant person. If there is not enough contact between the representative and the relevant person, the managing authority (The Trust) should inform the local Supervisory body</li> </ul>
Lead for Mental Capacity / Named Nurse for Safeguarding Adults	Responsible	<ul style="list-style-type: none"> <li>- Monitor the Deprivation of Liberty Applications, reporting on incidents, breaches, appeals and subsequent actions</li> <li>- Work with Managers to ensure Deprivation of Liberty applications are care co-ordinated and that decisions are communicated within the statutory time limit</li> <li>- Investigate in response highlighted incidents of noncompliance, in line with procedures for investigating serious incidents</li> <li>- Escalate any potential/actual breaches</li> <li>- Provide advice and guidance on DoLS and MCA matters</li> <li>- Notify the Care Quality commission of all DoLS application outcomes</li> <li>- Complete audit for compliance and standards of practice/ documentation and any potential breaches</li> <li>- Liaise with Trust Solicitors in areas of complex cases</li> </ul>
The Trust	Managing Authority	<ul style="list-style-type: none"> <li>- Ensure the Deprivation of Liberty Safeguards are implemented effectively within the Trust by providing systems which support the safeguards and monitoring compliance</li> <li>- Ensure Authorisations for deprivation of liberty are sought from the appropriate Supervisory Body in all instances where a person is considered to be deprived of their liberty</li> <li>- Ensure appropriate records are kept</li> <li>- Inform all relevant parties, including the patient, regarding the application details and outcomes of the deprivation of liberty safeguards process</li> <li>- Provide hard copies of received case documentation for the attention of the relevant person, and inform them of their rights under the Deprivation of Liberty Safeguards, in a suitable manner, and document this</li> <li>- Ensure all conditions which are stipulated in the authorisation are met, as far as feasible, in order to maintain the legality of the authorisation (see form 5). Where these are not feasible record attempts and steps taken to meet these conditions, and feed back to the Supervisory Body</li> </ul>

Title	Role	Key Responsibilities
		<ul style="list-style-type: none"> <li>- Review the care plans for the relevant person on a regular basis, ensuring that the restrictions in place are still necessary to ensure their safety and enable appropriate care, request a review if the care situation changes in respect of the authorisation, or if it is felt that the authorisation is no longer required</li> <li>- Inform the relevant persons representative (see end of form 5) of any changes in the care situation, and consult with the representative when making key support decisions</li> <li>- Request a renewal of the authorisation a minimum of 3 weeks (21 days) prior to the end of the authorisation period, failure to submit a renewal request, or review at the time it is felt the authorisation is no longer required, will result in a lapse and potential illegal deprivation</li> <li>- Inform the coroner's office immediately upon the death of any person under DoLS authorisation</li> <li>- (Complete and submit coroner's referral form, please cc the relevant DoLS team when submitting the form, for information and case closure. Death under DoLS authorisation is legally viewed as death in state detention, and the coroner must be informed immediately for potential inquest)</li> <li>- Inform the relevant DoLS team upon the relocation of the relevant person - authorisations are location specific and will cease on relocation of the relevant person</li> <li>- Ensure that staff are familiar with their responsibilities to maintain the authorisation</li> </ul>

## 5.0 APPROVAL

Safeguarding Steering Group

## 6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

### 6.1 What is a Deprivation of Liberty?

The requirement for the Deprivation of Liberty Safeguards remains unchanged. There are still 6 requirements which need to be met - is the patient:

- 18 and over;
- Suffering from a mental disorder;
- Lacking capacity for the decision to be accommodated in the hospital or care home;
- Have no decision previously made to refuse treatment or care, or conflict relating to this such as Lasting Power of Attorney;
- Not ineligible for DoLS, (this will be of significance and require consideration of the Mental Health Act, for those receiving treatment for a mental disorder within the Trust);
- The person is required to be deprived of liberty, in their best interests

## 6.2 Does the Mental Health Act 1983 Apply?

When a person lacking mental capacity is in a hospital or care home, receiving treatment for a mental disorder and is or is likely to have their liberty deprived consideration should be given as to whether to use the provisions of the Mental Health Act rather than DoLS. If the person fits the criteria for a mental health section to be applied then that should be the chosen route.

A mental health section does not normally allow treatment of a physical problem or illness that is unrelated to their mental health condition. In this circumstance a Mental Capacity Act may be used, and best interest conditions satisfied. However this will need to be assessed in the Multi-Disciplinary Team (MDT) or by the senior nurse/ Dr on call in emergency situations.

### 6.2.1 Factors that may indicate use of the Mental Health Act Rather than DoLS

- The patient's lack of capacity to consent to treatment and care is fluctuating or temporary and the patient is not expected to consent when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes;
- A degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally; and
- There is some other specific identifiable risk that the person or others might potentially suffer harm as a result. For example, if there is a risk that the person may need to be returned to the hospital or care home at some point in a manner that would not be authorised under DoLS

**Practice note:** Either DoLS or the Mental Health Act can be used.

The Mental Health Act Code of Practice (para13.58) comments; 'the choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision maker than the other ..... Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other.'

### 6.2.2 Disputes about Decisions Regarding Relevant Legislation

Where there are disputes between the Section 12 approved Mental Health Doctor or the Best Interest Assessor, regarding which legal provision the patient is to be treated under, this will need to be escalated immediately (see 4.2.2.1).

It is the responsibility of the Trust as the Managing Authority to ensure that all practicable steps are taken to ensure that the patient and the patient's relevant person's representative understand the effects of the Authorisation to manage conflict of decisions and actions and safeguard the patient's rights at all times.

## 6.3 Identifying Possible Deprivation of Liberty

### 6.3.1 Admission

When a person is about to be admitted or has been admitted to one of the Trust's inpatient wards and it is identified that the person lacks capacity to not only consent to admission but also lack capacity to make an informed decision about their proposed care and treatment whilst being under the care of the Trust, the patient may be at risk of being deprived of their Liberty. The clinical staff should ensure that all staff are able to identify any possibility that there may be a need for a deprivation of liberty authorisation. If a member of the clinical team believes a deprivation will take place that decision must be discussed in the multi-disciplinary team assessment.

Clinical staff must ensure that the potential relevant person has the capacity to agree to admission and the proposed care and treatment. If the person lacks capacity to consent to the admission then clinical staff should ask the person requesting the admission for the following information:

- Does the relevant person have anyone with Lasting Power of Attorney (LPA) (see **original document** and take a copy)
- If so, is the LPA for Health and Personal Welfare issues.  
<https://sfhnet.notts.nhs.uk/v2009/contentsearch09.aspx?st1=LPA&st2=flow&st3=chart&st4=&st5=>
- Does the person have a deputy appointed by the Court of Protection?
- If so, is the Deputy empowered for Health and Personal Welfare basis?
- Has the person made an Advance Decisions to Refuse Medical Treatment, which applies to anything, which may happen while they are in hospital?
- Does the Clinician/Matron/Ward Leader know of any wishes and feelings expressed by the relevant person, which relate to their care? (These are sometimes called Advance Statements)
- Does the referrer have the names of people who should be consulted when a major decision is being made?

If the person arranging the admission does not have this information, it should be sought from the GP or relatives.

The Supreme Court has now confirmed that to determine whether a person is objectively deprived of their liberty there are **2** key questions which staff need to ask themselves:

- 1) Is the person subject to *continuous supervision and control*?
- 2) *is the person free to leave?*

A yes to question 1) and a no to question 2) indicates that the requirements are met.

**Practice note:** continuous supervision and control refers to oversight even when the patient is not in the line of sight, it must amount to supervision and have a clear element of control. Not free to leave – the person may not be asking to go or showing this in their actions but the important factor is how staff would react if that person did try to leave or if a relative or friend asked to remove them.

This is now known as the 'Acid Test' and whether a patient is compliant or does not object to their care, treatment and accommodation is no longer relevant, neither is the reason or purpose behind these arrangements.

Initially clinical staff must review any previous decision made for individuals under their care where a patient's decision making capacity has been, or continues to be in question, i.e. where a patient has not given fully informed consent to admission and any treatment or care that is being provided, and where any care and/or treatment is currently being provided in the patient's best interest. In these cases Clinical Staff must formally assess the person's capacity.

Where it is established that the patient lacks capacity. This assessment must be fully documented on the two stage capacity assessment (Form1)

<https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=57539>

The clinical team will have to decide under which legal framework the care and treatment they are providing is being delivered:

- Under the Deprivation of Liberty Safeguards 2005, or
- Under the Mental Health Act 1983 (2015)

Where it is agreed that a person is deprived of their liberty and the Deprivation of Liberty Safeguards are the most appropriate legal framework then the appropriate delegated manager (ward leader/ matron) must complete an Urgent/Standard Authorisation and submit to the appropriate Local Authority DoLS Team.

It is important that a copy of the DoLS application form is emailed to:

[sfh-tr.safeguardingadults@nhs.net](mailto:sfh-tr.safeguardingadults@nhs.net) in order for the Trust Safeguarding/ Mental capacity lead, to complete this function.

A copy of the request must be printed and placed behind the red safeguarding divider in the clinical record.

## 6.4 Identifying the Managing Authority and Supervisory Body

The Trust has a statutory duty to ensure that DoLS are applied and monitored. DoLS require (managing authorities) authorisation from a Supervisory Body (local Authority) because depriving someone of their liberty is illegal without authorisation.

In NHS Hospitals the "Managing Authority" is the Trust Board, but responsibility for DoLS is delegated to Matron/Ward/ Department Leader.

The Supervisory Body will be the local authority for which the application for Deprivation of Liberty should be sent to, known as the patient's 'ordinary residence'

- If they own their own home, the Supervisory body will be the Local authority in that area
- If they are in a care home and self-funded, it will be the local supervisory body to that care home
- If they are funded by a local authority in a care home, the supervisory body will be the original local authority funding that care/ placement

## 6.5 Urgent Authorisations

If the person is considered to be deprived of their liberty with immediate effect then the Trust must also grant itself an Urgent Authorisation. Completing the DoLS application forms.

There will be occasions when it is discovered that a person who is already admitted is under circumstances, which may indicate that they are being deprived of their liberty, without valid authorisation. As soon as this is suspected it is the legal duty of the person who is delegated as the Managing authority to grant themselves an Urgent Authorization. If there was no authorisation the deprivation would be illegal and the Trust would be liable for prosecution. It is essential therefore that action is taken the instant that deprivation of liberty is suspected.

### 6.5.1 Unauthorised Deprivations of Liberty

If staff are concerned that an unauthorised deprivation of liberty has occurred or is likely to occur within the Trust then a senior clinician should review the situation and discuss with the Safeguarding Team as a matter of urgency and take steps to avoid any further, or prevent a potential future deprivation of liberty. In order to achieve this it may be necessary to apply an Urgent Authorisation.

**Practice Note:** A Deprivation of Liberty Authorisation issued to one Managing Authority cannot be transferred to another. A DoLS cannot be transferred with the patient. For example, patients transferred from Kings Mill Hospital to Newark/MCH Hospital, this would require the ending of the Kings Mill Hospital DoLS authorisation and a new DoLS to be requested at Newark/MCH.

### 6.5.2 Granting an Urgent Authorisation

- Fill in a Form 1. Request for urgent and standard request at the same time
- Send to the relevant local supervisory body (see ordinary residence guidance)

The Urgent authorisation lasts for 7 days. Day one starts the day the authorisation is signed and dated.

### 6.5.3 Requesting an Extension of an Urgent Authorisation

When completing a paper Form 1 to email to the relevant Supervisory body, the Urgent and Extension sections must be completed at the time of the application for authorisation.

The online portal will only allow selection of Urgent Authorisation.

## 6.6 Review: Form 10

The managing authority has a duty to review whether or not a deprivation of liberty authorisation is still required:

- When there are changes in circumstances in the relevant person's condition or arrangements which may indicate a change in their need for a deprivation of liberty (discharge or transfer)
- When a period of authorised deprivation is coming to an end
- If the Managing Authority is not certain about the continued deprivations of liberty

## 6.7 The Relevant Person's Representative

Every person who is made subject to an Authorisation under the Deprivation of Liberty Safeguards will have a Relevant Person's Representative appointed by the Supervisory Body as soon as possible after the Standard Authorisation is granted.

The Trust must ensure that the person who is deprived of their liberty and their Next of Kin/Significant other are made aware of:

- The effects of the Authorisation;
- The right to request a review;
- The formal and informal complaints procedures;
- Their right to apply to the Court of Protection to seek a variation or termination of the Authorisation;
- The right of the person who does not have a 'paid' relevant person's representative to request the support of an Independent Mental Capacity Advocate

There should be a supply of Rights leaflets and staff should give one to the relevant person, their representative and any other family /carers who are actively involved with the relevant person.

### 6.7.1 Independent Mental Capacity Act Advocate (IMCA)

The deprivation of liberty safeguards extended the IMCA roles. The original roles relate to decisions about accommodation, serious medical treatment, care reviews and safeguarding adults. IMCAs must be instructed to undertake each role by someone who is authorised to do so by the relevant local authority or NHS body. Where an IMCA is undertaking more than one role with an individual, they must be specifically instructed to do each of these by the appropriate body/ bodies.

#### 6.7.1.1 Facilitating IMCAs to Access the Records of Individual Service Users

IMCAs have a statutory right to examine the records of individuals referred to them. IMCAs will make themselves known to the nurse-in-charge of an in-patient area and will explain the circumstances and why they need to access a patient's records. The IMCA will have a recognised identity badge clearly displayed and the Nurse-in-charge may contact POHWER on the 0300 020 0093 to verify the IMCAs identity.

Access to records by an IMCA should be given the highest priority and be arranged to take place as soon as possible so that decisions about serious medical treatment and transfer from hospital can be finalised.

Details of the IMCA access to records must be documented in the medical notes/ nursing notes.

## 6.8 The Assessment under Deprivation of Liberty Safeguards

Once the Urgent/ Standard Authorisation has been submitted to the Local Supervisory Body (Local Authority) DoLS team they will arrange for the patient to be visited and assessed by a Mental Health Assessor, a Best Interest Assessor and an Independent Mental Capacity Advocate where appropriate. These individuals will determine whether the person meets the requirement of the Deprivation of Liberty Safeguards. During the assessment the assessors and if required the Independent Mental Capacity Advocate will visit the patient and may ask to examine and take copies of:

- Any health care records which relate to the person, and
- The person's Care Plan

The assessor/s will also need to consult with a senior member of staff and other staff on duty who know the patient. They will also consult with the patient's family/ significant others including LPA. Therefore it is important that where an application under DoLS is submitted, that the Ward/department ensures that the patient and the patient's family/ significant others are fully aware that the Urgent/ Standard Authorisation has been submitted.

### **6.8.1 Assessment Outcome**

Where the assessment concludes that the patient is eligible (lacks capacity and that they are deprived of their liberty in their best interest) the Supervisory Body will then issue a written Authorisation. This Authorisation will give details of the duration and purpose of the Authorisation and any conditions which may relate to it. Where there are conditions attached to the authorisation it is the responsibility of the Clinician/Matron/Ward Leader to ensure that these conditions are met and that the Supervisory Body is informed upon their completion.

Where an Authorisation is refused by the Supervisory Body the person's care will need to be reviewed **immediately**. A request for an assessment under the Mental Health Act should be sought.

It is imperative that any communicated decisions are documented in the notes of the patient, and the care plan.

## **6.9 Continuation of Deprivation of Liberty Safeguards**

Where it is expected that the patient will remain under the care of the Trust when the Standard Authorisation is due to expire, it is the responsibility of the Trust (Clinician/Matron/Ward Leader) to ensure that a new (DoL) Form 4 is submitted to the Supervisory Body 28 days before the original Authorisation expires.

## **6.10 Discharge**

When a patient who is subject to an Authorisation under the Deprivation of Liberty Safeguards either:

- No longer meets the requirement; or
- Is due to be discharged from the care of the Trust

Form 10 must be sent via email to the Supervisory Body and ensure that a copy is filed in the Medical Notes behind the Red safeguarding Divider.

## **6.11 Death of a DoLs Patient**

If the Deprivation of Liberty authorisation has been granted but the patient dies on the ward, the clinician is responsible for informing the coroner's office on the day of death by completing the Notification of Death Whilst Deprived of Liberty (Form 12) authorisation. This form should be faxed to the coroner and relevant local authority DoLs Team on the day of death.

Following the recommendation that DoL's be removed from the category "in state detention" section 178 of the Policing and Crime Act 2017. This has taken effect in relation to deaths which occur on or after the 3<sup>rd</sup> April 2017. Coroners are no longer required to hold an Inquest for anyone who dies whilst subject to a DoL however the Coroner needs to be informed through the Notification of Death Whilst Deprived of Liberty (Form 12) authorisation.



Due to the judgment within the Ferreira Case 2017 where a patient is sedated or dies on Intensive Care Unit (ICU) clinicians no longer need to apply for authorisation or report to the Coroner following a death unless there are suspicious circumstances. This is with effect from the 3rd of April 2017.

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

<b>Minimum Requirement to be Monitored</b>  (WHAT – element of compliance or effectiveness within the document will be monitored)	<b>Responsible Individual</b>  (WHO – is going to monitor this element)	<b>Process for Monitoring e.g. Audit</b>  (HOW – will this element be monitored (method used))	<b>Frequency of Monitoring</b>  (WHEN – will this element be monitored (frequency/ how often))	<b>Responsible Individual or Committee/ Group for Review of Results</b>  (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
How many Deprivation of Liberty Safeguard referrals	Safeguarding Team	The Safeguarding team maintain a record of how many patients are deprived of their liberty within the Trust	Quarterly Basis	Safeguarding Steering Group / Patient Safety Committee
How many staff have received Deprivation of Liberty Safeguard training	Training and Development Department / The Trusts Safeguarding Team	All staff who attend the training will sign a register of attendance and this information will be uploaded onto the OLM system. This information will be given to the Trusts Safeguarding Team on a quarterly basis who will formulate this information into a report.	Quarterly Basis	Safeguarding Steering Group/ Patient Safety Committee
How many Deprivation of Liberty Safeguard referrals and how many staff have received Deprivation of Liberty Safeguard training	Safeguarding team	The Report to the Safeguarding Steering Group and QPSC on a Quarterly Basis.	Quarterly Basis	Safeguarding Steering Group/ Patient Safety Committee

## 8.0 TRAINING AND IMPLEMENTATION

<b>What aspect(s) of this policy will require staff training?</b>	<b>Which staff groups require this training?</b>	<b>Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?</b>	<b>If no, how will the training be delivered?</b>	<b>Who will deliver the training?</b>	<b>How often will staff require training</b>	<b>Who will ensure and monitor that staff have this training?</b>
Basic Awareness MCA/DoLS Level 1	Staff requiring Level 1 safeguarding training.	Yes	E-Learning and mandatory workbooks	Learning and Development Team	On Induction and then yearly on mandatory	Workforce Development Group
MCA/DoLS – Included in Safeguarding Adults Level 2 and 3 Training	All qualified staff (eg. Registered nurses, medical staff and pharmacists)	No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities	Internally – face to face and e-learning for medics	Safeguarding Team	3 yearly	Safeguarding Team

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix 3](#)
- This document is not subject to an Environmental Impact Assessment

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

### Evidence Base:

#### **Mental Capacity Act 2005**

The Deprivation of Liberty Safeguards operates as part of the Mental Capacity Act 2005 and not instead of or in isolation from it.

Anybody working within the framework of the Mental Capacity Act 2005 (and hence the Deprivation of Liberty Safeguards) must work within the Act's 5 key principles:

- **Presumption of capacity:** A person must be assumed to have capacity unless it is proved otherwise
- **Maximising decision – making:** Until all practical steps have taken to help someone make a decision without success they cannot be treated as lacking capacity
- **Unwise decisions:** An unwise decision does not itself indicate lack of capacity
- **Best interests:** Any act done or decision for someone lacking capacity must be made in their best interests
- **Less restrictive option:** When a person lacks capacity any act or decision should aim to be a less restrictive option to the person in terms of their rights and freedom of action

#### **Care and Support between Local Authorities Regulations 2014**

These Regulations set out the procedures to be followed when disputes arise between local authorities regarding a person's ordinary residence under Part 1 of the Care Act 2014, or about the application of sections 37 (continuity of care and support – notification and assessment) or 48 (provider failure – temporary duty on local authority) of that Act. By virtue of section 117(4)(a) of the Mental Health Act 1983(a), the procedures applying to disputes regarding a person's ordinary residence under Part 1 of the Care Act 2014 also apply to disputes between local authorities about a person's ordinary residence for the purposes of section 117 of the Mental Health Act.

#### **Mental Health Act 1983 (amended 2015)**

The Mental Health Act (2015) amended the Mental Health Act (MHA) of 1983. The main purpose of the legislation is to ensure that 'people with serious mental disorders, which threaten their health or safety or the safety of other people can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others'. The amended act introduced:

- A new broad definition of 'mental disorder' to encompass 'any disorder or disability of the mind'
- An 'appropriate treatment test', preventing patients from being compulsorily detained unless appropriate medical treatment is available
- Community Treatment Orders to supervise the treatment of certain patients in the community

- New safeguards including a provision for Independent Mental Health Advisors to provide information and help people understand and exercise their rights
- New roles to replace the roles of approved social worker and responsible medical officer
- Provision for powers to reduce the time limits for the automatic referral of some patients to the Mental Health Review Tribunal

### **Human Rights Act 1998**

The Human Rights Act (1998) is one of the main laws protecting human rights in the UK, it contains a list of 16 rights (called articles) which belong to all people in the UK, and outlines several ways that these rights should be protected. These rights are drawn from the European Convention on Human Rights, which were developed by the UK and others in the aftermath of World War II.

The Human Rights Act may be used by every person resident in the United Kingdom regardless of whether or not they are a British citizen or a foreign national, a child or an adult, a prisoner or a member of the public.

The Human Rights Act has two main aims, to promote a 'culture of human rights' by making sure that basic human rights underpin the workings of government at the national and local level and enabling access to human rights here at home, instead of only being able to go to the European Court of Human Rights.

It does this by placing a legal duty on all public authorities, including NHS organisations and staff and mental health tribunals carrying out public functions, to respect and protect human rights in everything that they do. This means that public authorities have legal responsibilities for respecting, protecting and fulfilling human rights. This duty is important in everyday situations because it enables individuals to challenge poor treatment and to negotiate better solutions.

### **Data Protection Act 1998**

The Data Protection Act 1998 became law in March 2000. It sets standards that must be satisfied when obtaining, recording, holding, using or disposing of personal data. The law applies to data held on computers or any sort of storage system, including paper records.

There are 8 enforceable principles of good practice. Data should be:

- Fairly and lawfully processed
- Processed for limited purposes
- Adequate, relevant and not excessive
- Accurate
- Not kept longer than necessary
- Processed in accordance with the data subject's rights
- Secure
- Not transferred to countries outside the European Economic Area (EEA), without adequate protection

## **10.1 Links to Relevant National Standards**

### **Mental Capacity Act Codes of Practice (2007)**

The Code of Practice provides guidance on how the provisions of the Mental Capacity Act will work on a daily basis for those caring for, or working with, people lacking mental capacity.

The Code is important for professionals – such as doctors and social workers – but family, friends, and unpaid carers will also find it helpful. While certain groups of people are legally required to have regard to the Code when acting or making decisions on behalf of people lacking capacity, those who are not legally required to have regard to the Code are still encouraged to use it as a good practice guide.

The Code incorporates good practice and case studies, and demonstrates how the principles of the Act can be applied flexibly in particular circumstances.

### **Deprivation of Liberty Safeguards 2008 Code of Practice**

This Code of Practice provides guidance to anyone working with and/or caring for adults who lack capacity, but it particularly focuses on those who have a 'duty of care' to a person who lacks the capacity to consent to the care or treatment that is being provided, where that care or treatment may include the need to deprive the person of their liberty. This Code of Practice is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully.

### **Mental Health Act 1983 Code of Practice (2015)**

The Code provides guidance on how professionals can ensure that their roles and responsibilities under the Mental Health Act 1983 are carried out in a manner that ensures the delivery of safe and high quality care to patients.

The Code has a wide-ranging application; it applies to the care and treatment of all patients in England, who are subject to the exercise of powers and duties under the Act. The Code notes that the 1983 Act, "affects the lives and liberty of many people, impacting upon them, their families and community. In 2013-14, there were more than 53,000 detentions in England under the Act."

### **Key Changes in 2015**

- ✓ The introduction of 5 new overarching principles (listed below), which should always be considered when taking decisions on matters covered by the Act. Although each of the principles is of equal importance, the weight given to each principle in reaching a particular decision will vary depending on the context and nature of the decision being made.
- ✓ Additional chapters on equality and health inequalities, care planning and human rights.
- ✓ New guidance on when to use the 1983 Act and when to use the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- ✓ Additional guidance on blanket restrictions, immigration detainees, supporting patients (including young people) with autism and learning disabilities, supporting patients with dementia and physical health care.
- ✓ Revisions to the chapters on restrictive interventions (including seclusion and longer term segregation).

## The 5 Overarching Principles

### a. **Least restrictive option and maximising independence**

Where a patient can be treated safely and lawfully without detention under the 1983 Act, the Code is clear: the patient should not be detained. Wherever possible, the focus should be on promoting the patient's recovery and independence.

### b. **Empowerment and involvement**

Patients should be fully involved in decisions about their treatment, care and support and able to participate in decision-making as far as they can. Where appropriate, the views of the patient's family and carers should also be considered. A patient's views, wishes and feelings (including past, present and those expressed in advance) should be considered so far as they can be ascertained. With this in mind, the Code encourages professionals to support patients to develop advance statements of their feelings and wishes so that, during period of wellness, they may express views about their future treatment and care.

### c. **Respect and Dignity**

Not only should patients be treated with respect and dignity but these principles should also apply to the treatment of their families and carers.

### d. **Purpose and Effectiveness**

Decisions about a patient's care should:

- have a clear therapeutic aim
- promote recovery
- be performed to current national/best practice guidelines

### e. **Efficiency and Equity**

The organisations involved in providing care and treatment to patients should work together to ensure that mental health care services are of high quality and are given equal priority to both physical health and social care services.

## **CQC Regulation 9: Person-Centred Care**

The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.

Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment. Providers must make sure that decisions are made by those with the legal authority or responsibility to do so, but they must work within the requirements of the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate.

## **CQC Regulation 10: Respect and Dignity**

The intention of this regulation is to make sure that people using the service are treated with respect and dignity at all times while they are receiving care and treatment. To meet this regulation, providers must make sure that they provide care and treatment in a way that ensures people's dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local community.

Providers must have due regard to the protected characteristics as defined in the Equality Act 2010.

## 10.2 Links to other Key Policies

### Safeguarding Adults at Risk policy

Sherwood Forest Hospitals NHS Foundation Trust has a duty to safeguard adults from abuse. The Purpose of this policy is to provide guidance for staff to assist them in identifying adults at risk and recognising abuse. The Policy applies to all staff employed by the Trust including students and volunteers and will provide information regarding their duties and responsibilities in relation to responding to any concerns.

### Mental Capacity Act Policy

The purpose of this policy is to underpin the implementation of the MCA within the Trust by outlining the procedures to assess mental capacity, make decisions in the best interests of patients including patients who appear to have no family or friends to consult, use restraint, and follow valid and applicable advanced decisions. The Trust takes its responsibility for the care and treatment of patients seriously and aims to ensure compliance with legislation, statutory instruments and guidance.

### Mental Health Act 1983 Policy

The aim of the policy is to support staff in the effective implementation of the Mental Health Act, to ensure service users detained under the Act receive care and treatment lawfully and that they are able to exercise their rights at all times.

## 10.3 References

- The Mental Capacity Act 2005 Deprivation of Liberty Safeguards and you. Easy Read. DH. 2009
- Deprivation of Liberty Safeguards: A guide for hospitals and care homes. DH. 2009
- What is the Mental Capacity Act 2005 Deprivation of Liberty Safeguards? DH. 2008
- Mental Health act 1983: <http://www.legislation.gov.uk/ukpga/2007/12/contents>
- Case law; In Shah v London borough of Barnett [1983] 1 All ER 226.
- Gov.uk: Guidance on the identification of people in need of community service England
- The Ordinary Residence Disputes (National Assistance Act 1948)
- P&Q and Cheshire West (Supreme Court of Judgment, laid down on 19<sup>th</sup> March 2014)
- Section 45 Mental Capacity Act 2005 (Court of Protection)
- Office of Public Guardianship (OPG) <https://www.gov.uk/government/organisations/office-of-the-public-guardian>
- Guidance for restrictive physical interventions (Published by the Department of Health and Department of Education and skills.)

### Related SFHFT Documents:

- Mental Capacity Act (MCA) Policy
- Safeguarding Adults Policy
- Policy to consent for examination, treatment and care
- Guidance for the management of violence & aggression at SFH
- Guideline for the detection and management of acute confusion / delirium in adults
- Policy for the use of Restrictive Practices for Adult Patients
- Enhanced Observation Policy



## 11.0 KEYWORDS

safeguarding

## 12.0 APPENDICES

[Appendix 1](#) – Deprivation of Liberty Safeguards Flowchart

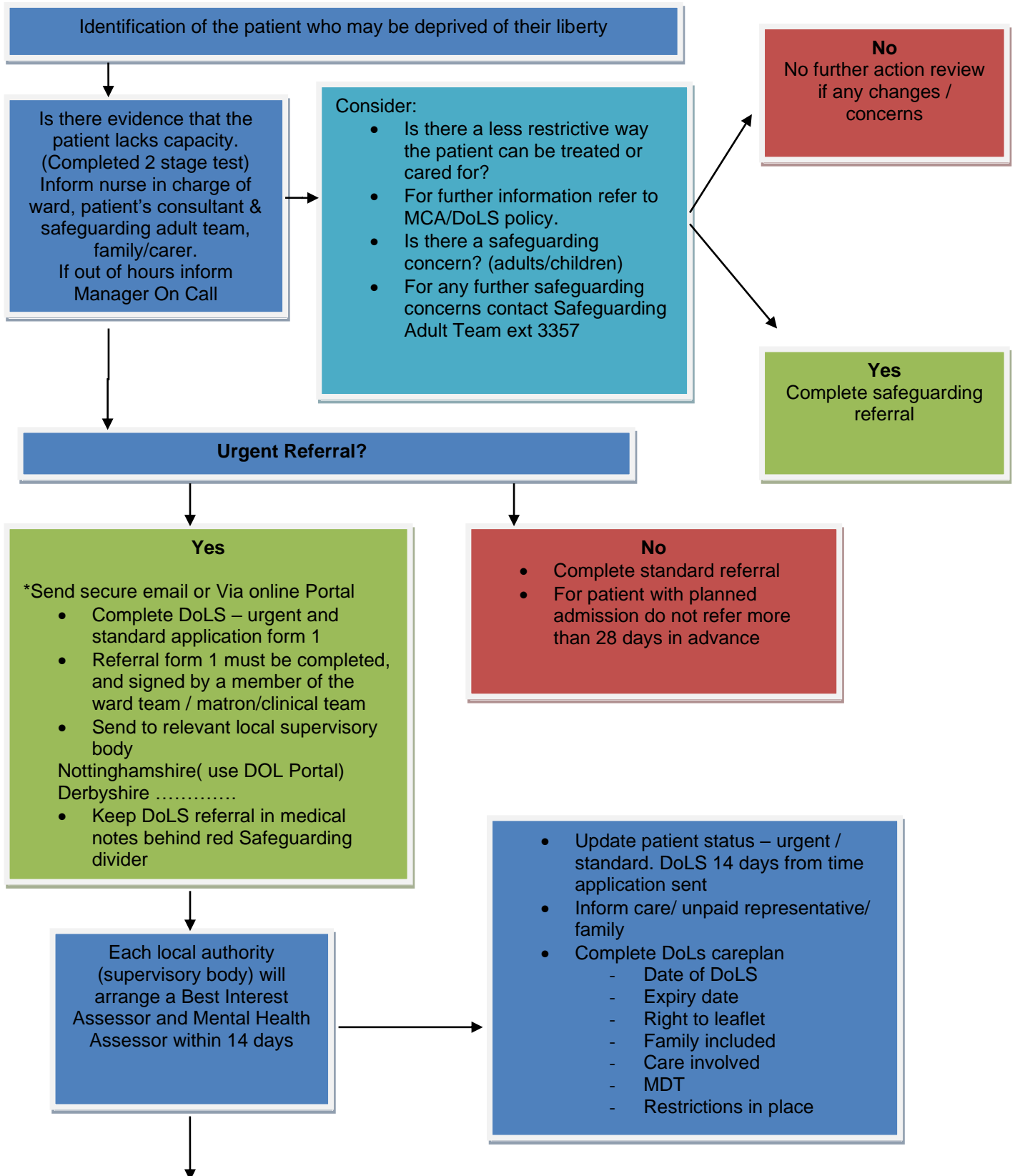
[Appendix 3](#) – Equality Impact Assessment Form

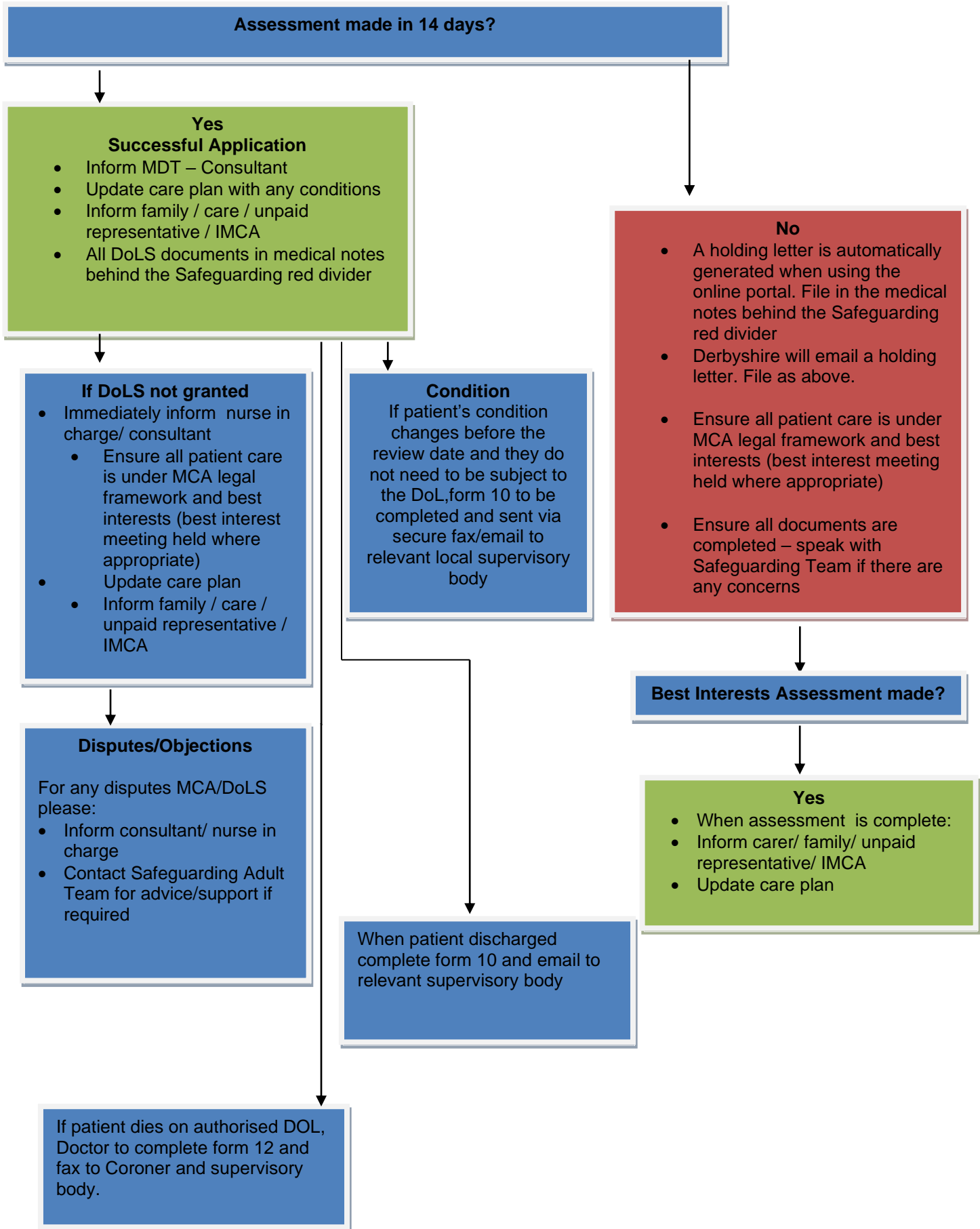
**Appendix 1**

**Deprivation of Liberty Safeguards Referral**

All the following forms are available on SFHT Safeguarding Adult intranet site.

**Deprivation of Liberty is defined as:**  
**“Under continuous supervision and control and are not free to leave” and lacks capacity to consent to the care and residence arrangements.**





### Appendix 3 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

<b>Name of service/policy/procedure being reviewed:</b> Deprivation of Liberty Safeguards (DOLS) Policy (for adults 18 years and over)			
<b>New or existing service/policy/procedure:</b> Existing			
<b>Date of Assessment:</b> 09/11/2021			
<b>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</b>			
<b>Protected Characteristic</b>	<b>a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?</b>	<b>b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?</b>	<b>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</b>
<b>The area of policy or its implementation being assessed:</b>			
<b>Race and Ethnicity</b>	This policy provides equitable care for all irrespective of race or ethnicity	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Gender</b>	This policy provides equitable care for all irrespective of gender	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Age</b>	This policy provides equitable care for all irrespective of age and is relevant to all patients over the age of 18 years	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Religion</b>	This policy provides equitable care for all irrespective of religion	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Disability</b>	This policy provides equitable care for all irrespective of disability	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Sexuality</b>	This policy provides equitable care for all irrespective of sexuality	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Pregnancy and Maternity</b>	This policy provides equitable care for all whether pregnant or not.	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Gender Reassignment</b>	This policy provides equitable care for all irrespective of gender	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>Marriage and Civil Partnership</b>	This policy provides equitable care for all irrespective of marital status.	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None

<b>Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)</b>	This policy provides equitable care for all irrespective of socio-economic status	This policy replaces the previous Deprivation of Liberty Safeguards Policy	None
<b>What consultation with protected characteristic groups including patient groups have you carried out?</b> <ul style="list-style-type: none"> <li>This policy acknowledges the needs of patients that require care from an acute perspective. To ensure that it is compliant with all legislation it has been shared with senior medical/nursing and safeguarding colleagues for consultation and feedback to ensure that it effectively meets the needs of all staff and patients</li> </ul>			
<b>What data or information did you use in support of this EqIA?</b> <ul style="list-style-type: none"> <li>Nottinghamshire and Nottingham City Safeguarding Adults Boards [2016] Safeguarding Adults Procedures • NHS Employers Employment Check Standards [2010] • Care Act (2014) • Mental Capacity Act (2005) Deprivation of Liberty Safeguards (2009)</li> </ul>			
<b>As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?</b> <ul style="list-style-type: none"> <li>None</li> </ul>			
<b>Level of impact</b>  From the information provided above and following EQIA guidance document Guidance on how to complete an EIA ( <a href="#">click here</a> ), please indicate the perceived level of impact:  High Level of Impact/Medium Level of Impact/Low Level of Impact ( <i>Delete as appropriate</i> )  For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.  Low Level of Impact			
<b>Name of Responsible Person undertaking this assessment: Julie Spizer</b>			
<b>Signature:</b>			
<b>Date: 09/11/2021</b>			