

Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Document History	
Lead/Author(s)	Eve McGrath
Version and date	V1.1 11/12/2018
Approved by	BHR CCG Quality and Safety Committee
Approval / Implementation date	12 February 2019
Review date	February 2022
Target audience	All BHR CCGs Staff
Date of equality impact assessment	30/11/2018
Policy reference number	Cor/xx_0xx

Version History				
Date	Version	Author	Status	Description of change/comments
30/11/2018	1.0	Eve McGrath	Draft	New policy
11/12/2018	1.1	Rod McEwen Legal and Governance Adviser	Final draft for approval	Advice and comments included

INDEX

No	Section	Page No.
1	Introduction	3
2	Purpose	3
3	Scope	3
4	Definitions	4
5	Roles and Responsibilities	5
6	Consultation	8
7	Mental Capacity Act and MCA assessments	9
8	Deprivation of Liberty Safeguards (DoLS)	20
9	Monitoring and Compliance	24
10	Education and training	25
11	References	25
	<i>Appendices</i>	
1	Equality Impact Assessment (EIA)	27
2	Mental Capacity Act 2005 Pathway	28
3	Deprivation of Liberty Pathway	29
4	Mental Capacity Assessment and Best Interest Decision Form	30

1. Introduction

- 1.1 The [Mental Capacity Act 2005 \(MCA\)](#)¹ creates a legal framework to provide protection for people who cannot make decisions for themselves. It applies to everyone who works in health and social care and is involved in the care, treatment or support of people who are 16 years of age or more (England and Wales).
- 1.2 The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of people who lack mental capacity. It is supported by a Code of Practice (MCA Code 2005)².
- 1.3 The underlying philosophy of the MCA is that any decision made, or taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA 2005 applies irrespective of whether the decision is a day to day matter, or relates to serious medical treatment.

2. Purpose

- 2.1 The purpose of this policy is to set out the roles and responsibilities of Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group (BHRCCG) and its employees to comply with the MCA and Deprivation of Liberty Safeguards (DoLS)³ and it's Code of Practice⁴.

3. Scope

- 3.1 This policy applies to all employees of CCG. In particular to those working in Continuing Healthcare who visit patients and their families and carers, and those who are responsible for commissioning NHS funded nursing care and NHS continuing healthcare.
- 3.2 GP's who are acting as representatives of CCG in a remunerated or unremunerated capacity should have regard to this policy.
- 3.3 Continuing Healthcare (CHC) professionals who are assessing patient capacity for decisions relating to funded nursing care or continuing healthcare should have regard to this policy.

¹ <http://www.legislation.gov.uk/ukpga/2005/9/contents>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

³ <https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards>

⁴ http://webarchive.nationalarchives.gov.uk/20110322122009/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

- 3.4 The CCG will inform other commissioners of care or treatment services about any safeguarding concerns regarding non-compliance with the MCA 2005 or DoLS where services are commissioned in coordination with the CCG.
- 3.5 The CCG will inform the police if it has reason to believe a crime has been committed under section 44 of the MCA 2005 (the ill treatment or willful neglect of an adult who lacks capacity).
- 3.6 The policy should be read in conjunction with the Mental Capacity Act 2005 Code of Practice the Deprivation of Liberty Safeguards 2008 and the Cheshire West Supreme Court Judgment 2014⁵.

4. Definitions

- 4.1 A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of an impairment, or a disturbance in the functioning of the mind or brain.
- 4.2 An impairment or disturbance in the brain could be as a result of (not an exhaustive list):
- A stroke or brain injury
 - A mental health problem
 - Dementia
 - A significant learning disability
 - Confusion, drowsiness or unconsciousness because of an illness or treatment f
 - A substance misuse.
- 4.3 Lacking capacity is about a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.
- 4.4 It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at different times for the same person. An assessment of a person's capacity needs to be carried out each time a decision has to be made. Even if a person has an ongoing condition that affects

⁵ https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

his capacity to make certain decisions, assessments have to be reviewed as particular decisions need to be made.

- 4.5 Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.
- 4.6 Lack of Capacity must be established following the processes outlined in **Appendix 2** and using the Mental Capacity Assessment and Best Interest Decision Form attached at **Appendix 4**.

5. Roles and Responsibilities

- 5.1 The CCG will ensure that all staff are aware of their responsibilities under the MCA and will ensure that employees operate at all times in accordance with the MCA and the accompanying code of practice.
- 5.2 CCGs have statutory responsibility for ensuring that the organisations from which it commissions services provide a safe system which safeguards adults at risk, including adults who lack mental capacity. The CCG will therefore ensure that they commission MCA compliant services.
- 5.3 The CCG's quality monitoring and assurance processes will require providers to evidence that they work in accordance with these principles and the ethos of the MCA 2005. For example:
- People must be assumed to have capacity to make their own decisions, therefore an assessment of mental capacity should reference the reason the assessor suspects the person does not have capacity to make the specific decision, not just the fact that the person has an impairment or disturbance in the way their mind or brain function.
 - Providers should record evidence of the tools and resources they use to help people make decisions, including the use of translation services.
 - Autonomy and human rights should be central to good healthcare practice. However, safeguarding concerns must not be overlooked. Safeguarding processes should refer to evidence of any unwise decision and capacity, and how these are managed (e.g. high risk panels for those who self-neglect and hoard).

- Providers should evidence use of the best interest process, and consultation with those who support the service user.
- Independent Mental Capacity Advocates (IMCA) referrals and referrals to advocates should be recorded and audited.
- Providers should be able to demonstrate less restrictive practices, and have policies for the safe use of restraint.
- The provider will ensure that all relevant policies and procedures are consistent with legislation/guidance in relation to the MCA 2005, and that staff practice in accordance with these policies
- Providers will ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body or Court of Protection.
- NHS Trusts must have a robust annual audit programme in place to assure itself that practices are consistent with the MCA 2005, to be shared with the CCG on request.
- Providers will ensure that all staff providing care or treatment understand the principles of the MCA 2005 and undertake training appropriate to their role and level of responsibility. Regular comprehensive training needs analysis will help determine which groups of staff require more in depth training.

5.4 The CCG will have regard for recent developments in relation to the MCA 2005 such as the Government's recommendations following the House of Lords Select Committee post-legislative scrutiny on the MCA 2014⁶, ADASS 'Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance'⁷ and the Mental Capacity (Amendment) Bill⁸.

5.5 Ensuring that commissioned services are safe for adults at risk (including those who may lack capacity) and have relevant, an up to date MCA and DoLS policy in place.

5.6 Following the empowerment agenda for its patients who may lack capacity - the first principle of the Government policy on Adult Safeguarding is "empowerment –

⁶ <https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm>

⁷ <http://londonadass.org.uk/wp-content/uploads/2014/12/MCA-commissioning-compliance-guide.pdf>

⁸ <https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html>

presumption of person-led decisions and informed consent.” This is consistent with the ethos of the MCA.

5.7 The **Nurse Director** is the executive lead for the MCA 2005. Responsible for:

- Ensuring that all service plans, specifications, contracts and invitations to tender reference the MCA 2005 and DoLS, the expectations of the CCG for compliance, and the standard of evidence demonstrating that compliance.
- Ensuring those CCG employees in contact with service users, their families and carers in the course of their normal duties are trained and competent to complete MCA 2005 assessments and have regard for the MCA and DoLS Codes of Practice.
- Ensuring that MCA 2005 implementation is integral to clinical governance and audit arrangements.

5.8 The **Adult Designated Nurse for Safeguarding** for the CCG is responsible for:

- Having due regard to the MCA and DoLS Codes of Practice.
- Ensuring that all staff and member practices are aware of, and comply with, their responsibilities under the MCA 2005 and its associated MCA and DoLS Codes of Practice.
- Ensuring that MCA 2005 and DoLS training is offered to CCG staff.
- Engaging with the local Safeguarding Adults Board and its sub groups
- Working in partnership with the Local Authority, Provider Safeguarding Leads, CQC and the police to ensure consistent leadership on MCA 2005 and DoLS across the local health economy.
- Working with commissioners and contract managers to ensure that contracts specify compliance with the MCA 2005 and DoLS provisions.
- Ensuring that learning from Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews, where mental capacity has been a factor, is applied and used to inform healthcare practice.
- Communicating recent legal developments in relation to the MCA 2005.
- Liaising with the local authority DASM and MCA Lead to ensure coordinated support for health and social care providers.

- Checking DoLS applications from CHC team and forwarding them to the CCG Legal Team for progression to the Court of Protection.

5.9 **Continuing Healthcare** employees are responsible for:

- Attending MCA 2005 and DoLS training.
- Being familiar with the principles and practice of the MCA 2005.
- Promoting the use of advance decisions and lasting powers of attorney when appropriate.
- Understanding the principles of confidentiality and information sharing in line with the MCA 2005 and wider professional obligations and are to contribute when requested to do so, to best interests meetings when related to funding of placements.
- Completing assessments of capacity (if necessary) when assessing or reviewing patients for funded nursing care or continuing healthcare.
- Acting as the best interests decision maker when appropriate related to decision in question.
- Referring their patient to an advocacy service as required, ensuring that decisions made in a person's best interest are clearly documented.
- Alerting safeguarding professionals in the local authority if they suspect abuse or neglect of a person without capacity.
- Recording assessments relating to mental capacity and identifying people who they believe meet the criteria for Community Based Deprivations.
- Completing Court of Protection (CoP) COPDOL 11 application forms and forwarding them to the CCG Adult Designated Nurse for Safeguarding for checking.

6. **Consultation**

This policy has been reviewed in line with CCG governance processes. The following stakeholders have been consulted:

- Nurse Director
- Members of Integrated Safeguarding Adult Board
- Continuing Healthcare Team
- Legal and Governance Adviser, Solicitor and In House Counsel for BHRCCG
- BHR CCG Quality & Safety Committee.

7. Mental Capacity Act and MCA assessments

7.1 The MCA has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number.

7.2 For the purpose of the Mental Capacity Act 2005, a person lacks capacity if:

“They have an impairment or disturbance that affects the way their mind or brain works and because of this they are unable to make a specific decision at the time that it needs to be made”. (MCA Code of Practice - Chapter 4: para 4.3).

7.3 There are five statutory principles which are the benchmark of the MCA and must underpin all acts carried out and decisions taken in relation to the Act. The principles are designed to help people take appropriate action in individual cases and help people find solutions in difficult or uncertain situations:

Principle 1 – A person must be assumed to have capacity unless it is established that they lack capacity.

Principle 2 – A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.

Principle 3 – A person is not to be treated as unable to make a decision merely because they make an unwise decision.

Principle 4 – Any act done, or any decision made on behalf of a person who lacks capacity must be done, or made, in their best interests.

Principle 5 – Before someone makes a decision or acts on behalf of a person who lacks capacity, they must always consider if something else could be done that would interfere less with the person’s basic rights and freedoms. This consideration should include whether there is a need to act or make a decision at all.

7.4 The statutory principles aim to:

- protect people who lack capacity and help them take part, as much as possible, in decisions that affect them.
- They aim to assist and support people who may lack capacity to make particular decisions, not to restrict or control their lives.

7.5 **Assessing capacity process**

Lack of capacity cannot be demonstrated by referring to a person's age or appearance, condition or any aspect of their behaviour.

7.6 Capacity is about the ability to take a particular decision at the time it needs to be taken. It is decision-specific and time-specific. There can be no assumption that an individual will always lack capacity to make a range of decisions.

7.7 Where the person's capacity to make a decision has come into doubt, staff should consider the following:

- Has sufficient effort been made to help and support the person to make the decision in question?
- Is the decision required imminently, or can it be delayed until the person has sufficient capacity to make the decision themselves? A person may temporarily lack capacity, e.g. if they are taking medication which makes them drowsy.

7.8 The Act assumes that a person has capacity until it is proved otherwise. There is a two stage capacity test which should be used when determining if a person may lack capacity under the definition provided by the Act:

Stage 1 - Diagnostic test:

Does the person have an impairment of, or disturbance in the functioning of, the mind or brain (whether permanent or temporary)?

Stage 2 - Functional test:

Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

7.9 If the diagnostic test establishes that a person has an impairment of the mind or brain or there is some sort of disturbance affecting the way their mind or brain works, the second tier test (functional test) is undertaken to assess a person's ability to make a decision for themselves.

7.10 A person is unable to make a specific decision if they cannot:

- **Understand** information relevant to the decision:
 - The person must be able to understand the nature of the decision and the consequences. The understanding doesn't need to be in depth, broad understanding is acceptable under the MCA 2005.
 - The information should include possible options, and what happens if the decision is not made.
 - All possible help must be given to the person to understand the information, including using simple language and visual aids if needed.
 - The assessor should undertake the assessment in the best environment for the person and at the best time of day for them.
- **Retain** that information
 - The information only needs to be retained for long enough to make the decision in question. There is no set time limit for how long this is.
 - The person only needs to have capacity at the time the decision needs to be made. It might be necessary to repeat the discussion again at another time before the action is taken to demonstrate that the person's decision is the same.
 - It is important to help the person retain the information, use of notes, or recording the decision are steps that could be taken.
- **Use or weigh** that information as part of the process of making the decision
 - The person should be able to demonstrate that they understand the consequences of the decision.
 - This might mean giving them time to think about it, and to weigh the advantages and disadvantages.
 - It might be necessary to involve another person to help in the weighing up process, such as an advocate, carer, friend or family member.

- **Communicate** their decision by any means (this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand).
 - The assessor should ensure that the person's capacity is not misjudged because they have difficulty understanding them.
 - The assessor must record that the lack of capacity to make the decision is caused by the impairment or disturbance in the functioning of the person's mind or brain, and not due to other factors (such as outside influence or coercion, a history of being an indecisive person or the decision being significant and the person needs more time to consider it).

7.11 **Best Interest Decision Making**

It is recognised that most significant decisions regarding someone who lacks capacity will be made in the context of a multi-disciplinary discussion. However, the 'decision-maker' is the person who is likely to be proposing to take action, and is likely to be a nurse, social worker/care manager or doctor.

7.12 The process of working out the best interests of the person for each relevant decision should be formally documented in the person's record and should include:

- how the decision about the person's best interests was reached
- the reasons for reaching the decision
- who was consulted to help work out the person's best interests
- what particular factors were taken into account.

7.13 If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests (MCA principle 4).

7.14 The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day to day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation have to be made.

7.15 The MCA 2005 Code of Practice directs that a person trying to establish the best interests of a person who lacks capacity to make a particular decision should provide a checklist of factors to be followed to ensure decisions taken are in the person's best interest (please see **Appendix 4** for the MCA template for documentation purposes):

➤ **Encourage participation**

- Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision.
- Identify all relevant circumstances
- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

➤ **Find out the person's views**, try to find out the views of the person who lacks capacity, including:

- The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
- Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
- Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

➤ **Avoid discrimination**

- Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- Assess whether the person might regain capacity
- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

7.16 If the decision concerns life-sustaining treatment

- Do not be motivated in any way by a desire to bring about the person's death.
- They should not make assumptions about the person's quality of life.

7.17 Consulting others

If it is practical and appropriate to do so, staff need to consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.

7.18 In particular, they need to consult:

- anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
- anyone engaged in caring for the person, close relatives, friends or others who

take an interest in the person's welfare

- any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
- Any deputy appointed by the Court of Protection to make decisions for the person

7.19 For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

7.20 When consulting, remember that the person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone.

7.21 Avoid restricting the person's rights and see if there are other options that may be less restrictive of the person's rights.

If you are making the decision under the Mental Capacity Act you must take the above steps, amongst others and weigh up the above factors in order to determine what is in the person's best interests. For more information you should refer to the Code of Practice.

7.22 **Independent Mental Capacity Advocate (IMCA) service**

The IMCA service was created under the MCA 2005 to support people who lack capacity to make certain important decisions and, at the time such decisions need to be made, who have no-one else (other than paid staff) to support and represent them or be consulted.

7.23 An IMCA must be instructed if the decision to be made relates to:

- An NHS body proposing to provide serious medical treatment
- An NHS body or local authority proposing to arrange accommodation (or change of accommodation) in hospital or care home, and
- The person will stay in hospital longer than 28 days, or
- They will stay in the care home for more than eight weeks.

7.24 An IMCA may also be instructed to support someone concerning:

- Care reviews
- Safeguarding processes. An IMCA can be instructed for those who need support during a safeguarding investigation, even if they have family or friends.

7.25 The information provided by the IMCA must be taken into account by the decision maker.

7.26 **Section 5 MCA (Actions)**

Section 5 permits the performance of an action in connection with the care and treatment of a person who lacks capacity to consent to it (it makes lawful what could otherwise give rise to a civil claim or criminal charge).

7.27 **Personal care**

- helping with washing, dressing or personal hygiene
- helping with eating and drinking
- helping with communication
- helping with mobility (moving around)
- helping someone take part in education, social or leisure activities
- going into a person's home to drop off shopping or to see if they are alright
- doing the shopping or buying necessary goods with the person's money
- arranging household services (for example, arranging repairs or maintenance for gas and electricity supplies)
- providing services that help around the home (such as homecare or meals on wheels)
- undertaking actions related to community care services (for example, day care, residential accommodation or nursing care) –
- helping someone to move home (including moving property and clearing the former home).

7.28 **Healthcare and treatment**

- carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
- providing professional medical, dental and similar treatment
- giving medication

- taking someone to hospital for assessment or treatment
- providing nursing care (whether in hospital or in the community)
- carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example, physiotherapy or chiropody)
- providing care in an emergency.

7.29 Section 5 does not protect against civil liability for loss and damage resulting from the negligent performance of the action.

7.30 **Section 6 MCA (Restraint)**

7.31 Staff will be only be protected from liability regarding any action intended to restrain a person who lacks capacity under the following two conditions:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be proportionate to the likelihood and seriousness of harm.

7.32 Staff should consider less restrictive options before using restraint. The MCA Code of Practice (paragraph 6.48) suggests that where possible other people involved in the care of a person who lacks capacity should be consulted regarding what action may be necessary to protect the person from harm.

7.33 Section 6 permits restraint of a person who lacks capacity. Restraint is defined as:

- the use - or threat to use - force to make someone do something they are resisting;
or;
- Restricting a person's freedom of movement, whether they are resisting or not.

7.34 Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person and it is proportionate response to the likelihood and seriousness of harm.

7.35 Less restrictive options must always be considered before restraint is used. The use of restraint must only be considered in the best interests of the person and must be the minimum needed to achieve the desired outcome.

7.36 Liberty restricting measures are not the same as liberty depriving measures. The difference between the two is one of degree or intensity, not nature or substance. The MCA 2005 does not permit staff to deprive a person who lacks capacity of their liberty - instead, this must be authorised by the Supervisory Body under the DoLS scheme or the Court (assuming of course that it is not a deprivation of liberty required for the purpose of providing him with emergency medical treatment for either a physical or mental disorder while a decision on a relevant issue is sought from the Court).

7.37 **Lasting Power of Attorney (LPA)**

People can be given statutory authority to make treatment decisions on another person's behalf, once they have lost mental capacity, by making a health and welfare lasting power of attorney.

7.38 There are two types of lasting power of attorney, health and welfare and property and finance. A health and welfare LPA can be created while a person still has capacity to give authority to an attorney to make decisions when they are no longer able to consent to treatment or care. The attorney may be given power to make decisions about day to day care, consenting or refusing medical treatments, moving accommodation, refusing life sustaining treatment and more.

7.39 A lasting power of attorney must be registered with the Office of the Public Guardian before it is valid. Records must reflect whether an LPA has been registered, and what decisions are given to the attorney.

7.40 Some patients may wish to plan ahead for their health and social care knowing that there may be a time in the future when they are unable to consent. There are different ways a person can do this:

- **Verbally** – Conversations with family, friends, and healthcare professionals about their wishes and preferences.
- **Advance Statement** or preferred priorities for care form. This is a non-legally binding document that those involved in treatment and care should take into consideration when making a best interests decision. It is a statement of the views and wishes of the individual, and might reflect the treatment preferences.

- **An Advance Decision** (to refuse treatment life and non-life threatening) this is a legally binding document that allows the individual to say what treatments they do not want and under what circumstances at a time in the future when they do have capacity to make those decisions.

7.41 **Disputes Process (see MCA Code of Practice, chapters 8 & 15)**

There are likely to be occasions when someone may wish to challenge the results of an assessment of their capacity, best interests' determination, or decisions or actions made on their behalf. The challenge may come from the individual who is said to lack capacity, or by someone acting on their behalf, such as a relative or an advocate.

7.42 Firstly, the challenge should be raised with the person who carried out the assessment, decided on best interests or made decisions or actions on a person's behalf to determine the reasons why they made such a decision and to ascertain objective supporting evidence. This should then be discussed with the person raising the challenge with a view to resolving the dispute.

7.43 Other steps which can be taken may include:

- Getting a second opinion from an independent professional or another expert in assessing capacity
- Using the local complaints procedure
- Using mediation
- Setting up a case conference.
- Advocates can be involved in any of the steps taken to resolve a disagreement.
- Members of staff should discuss with their line manager to seek further guidance.

7.44 If a disagreement cannot be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection who can rule whether the person in question has capacity to make the decision in question.

7.45 **Court of Protection**

The Court of Protection deals with decision making for adults (and children in a few cases) who may lack capacity to make decisions for themselves.

7.46 The Court of Protection has the same powers, rights, privileges and authority as the High Court. When reaching any decision the court must apply all the statutory principles set out in section 1 of the MCA.

7.47 The Court has powers to:

- make declarations about whether or not a person has capacity to make a particular decision
- make decisions on serious issues about healthcare and treatment
- make decisions about property and financial affairs of a person who lacks capacity
- make decisions in relation to Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs)
- appoint deputies to have an ongoing authority to make decisions
- remove deputies or attorneys who fail to carry out their duties.

7.48 The Court can also use its 'inherent jurisdiction' to make interim declarations pending its decision about whether someone has capacity which means we can apply to the court for a short term decision whilst a dispute about capacity is determined.

7.49 If it is felt that a Court of Protection decision is required this should be discussed within the MDT and with the MCA Lead for the trust – currently held within the Corporate Safeguarding Adults Team.

7.50 **Court of Protection: section 49 power to call for reports**

Section 49 of the Mental Capacity Act 2005 gives the Court of Protection the power to require a Local Authority or an NHS body, to arrange for a report to be made.

7.51 In these circumstances the Court will serve on the Trust an order for a report, setting out the terms of reference for the report. The Order will usually contain information about who the Court expects to complete the report – for example a Consultant Psychiatrist.

7.52 Reports under section 49 are usually called for to enable the Court to discharge its duties. They are information reports for the court and expected to be delivered as part of NHS core business.

7.53 Further information can be found in the Court of Protection Guidance and Directions⁹.

7.54 **Court of Protection: Court Appointed Deputies (MCA Code of Practice, Chapter 8)**

The MCA provides for a system of court appointed deputies to make decisions on matters for which a person lacks the capacity of make decisions for themselves.

7.55 In the majority of cases, deputies will be either a relative or someone well known by the person who lacks capacity, but in some cases may be someone independent of the situation.

7.56 Deputies will be able to take decisions on welfare, healthcare and/or financial matters as authorised by the Court, but will not be able to refuse consent to life-sustaining treatment. As in the case of LPAs, the welfare and finance responsibilities may be combined or shared.

7.57 Deputies will only be appointed where future or ongoing decisions are required and the Court cannot make a one-off decision to resolve the issue.

7.58 Deputies have to pay attention to the guidance in the MCA Code of Practice, have to act in the best interests of the person who lacks capacity & make sure they only make decisions that they are authorised to make by the order of the court.

8. Deprivation of Liberty Safeguards (DoLS)

8.1 The **Mental Capacity Act 2005 (MCA)**¹⁰ is the statutory framework for acting and making decisions on behalf of individuals over 16 years old who lack the capacity to make particular decision for themselves or who have the capacity and want to make preparations for a time when they may lack capacity in the future.

8.2 **Deprivation of Liberty Safeguards (DoLS)** is an amendment to the MCA 2005. They apply in England and Wales only. The MCA framework allows restraint and restrictions to be used – but only if they are in a person’s best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called

⁹ <https://www.judiciary.uk/wp-content/uploads/2015/06/copd-pd-9d-existing-deputies-attorneys-and-donees.pdf>

¹⁰ http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can be asked if a person can be deprived of their liberty. The DoLS applies to adults aged 18 years and over. Please see the 'Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice'¹¹ for further details.

- 8.3 The DoLS were created to help protect vulnerable people who lack capacity to consent to treatment that might deprive them of their liberty, where this care or treatment is in their best interests or will protect them from harm. The Act provides a legal process for this deprivation which makes sure that it is unavoidable and in the persons' best interests.
- 8.4 The DoLS only relate to people aged 18 or over and those adults that are not detained under the Mental Health Act 1983.
- 8.5 The Supreme Court laid down an acid test to assist homes and assessors to identify a deprivation of liberty on 19 March 2014. This **acid test** states a person is deprived of their liberty if:

'The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.'

- 8.6 The Supreme Court ruled that the **following factors are not relevant** to whether or not someone is deprived of their liberty:
- the person's compliance or happiness or lack of objection
 - the suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition)
 - the reason or purpose leading to a particular placement.

8.7 **How is deprivation of liberty authorised under DoLS?**

Deprivation of liberty can occur in a care home, hospital or domestic setting such as supported living accommodation.

¹¹

http://webarchive.nationalarchives.gov.uk/20110322122009/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

8.8 Six assessments are needed in order to satisfy the requirements of the MCA DOLS and need to be completed in the following order, are:

- Age assessment
- No refusals assessment
- Mental capacity assessment
- Mental health assessment
- Eligibility assessment
- Best interests assessment.

8.9 **Hospital and Care Homes (Managing Authorities)**

Where a managing authority thinks it needs to deprive someone of their liberty they have to ask for this to be authorised by a 'supervisory body.' They can do this up to 28 days in advance of when they plan to deprive the person of their liberty. Under DoLS the supervisory body is the local authority. For care homes, this is the local authority where the person is ordinarily resident. Usually this will be the local authority where the care home is located, unless the person is funded by a different local authority.

8.10 The Local Authority 'Supervisor Body' has a duty to determine whether or not to authorise the deprivation of liberty of a person who lacks capacity and lives in a care home or is in hospital, when the care home or hospital makes an application for this to be done.

8.11 The 'Managing Authority' should request an urgent and standard authorisation (DoLS Form 1). This is sent to the 'Supervisory Body' which has 28 days to decide whether the application is authorised. The supervisory body appoints assessors to see if the conditions are met to allow the person to be deprived of their liberty under the safeguards.

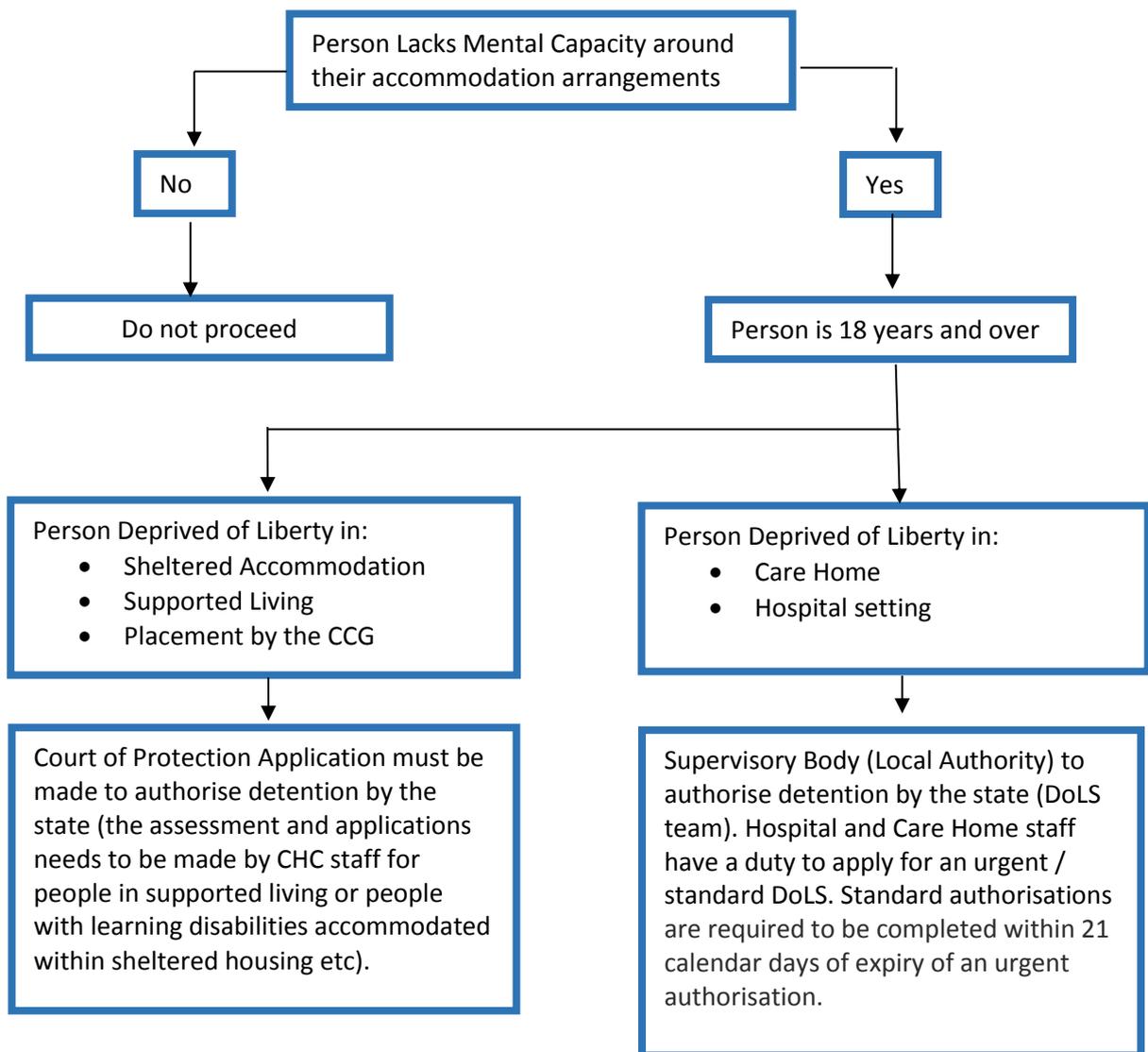
8.12 **Domestic settings**

The CCG, as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of vulnerable adults who lack mental capacity under the MCA 2005 around their accommodation arrangements and are being Deprived of their Liberty under Article 5 (Right to Liberty and Security) of the Human Rights Act 1998¹² and European Convention on Human Rights.

¹² https://www.legislation.gov.uk/ukpga/1998/42/pdfs/ukpga_19980042_en.pdf

- 8.13 It is important that the CCG as commissioners of services have oversight that residents in their area and that the rights of the population on whose behalf it is commissioning services are protected in relation to the safeguards. It will wish to be assured that patients are not being deprived of their liberty unlawfully and that when service users require the protections the safeguards offer they are in place.
- 8.14 Continuing Health Care (CHC) Professionals have a duty to identify placements where people lack mental capacity around their accommodation arrangements and make necessary arrangements to safeguard them. In instances, where a person is living in sheltered and supported living and care is provided, the same process applies, but only the Court of Protection (CoP) can authorise this. For people within domestic settings, applications are made to the Court of Protection (COP). The care provider must however inform the local authority or the organization commissioning the individual's care; who would then make the application to the COP. Where the CCG is funding the CHC care/PHB for the patient, it will fall to the CCG to make any DoLS application.
- 8.15 When CHC staff identify a person who they believe meets the criteria for a Community Based Deprivation application, they should complete COPDOL 11 application form and forward to the CCG's Designated Adult Nurse for Safeguarding together with a full copy of the care and treatment plan.
- 8.16 CHC staff are responsible for:
- Ensuring that decisions are taken reviewed and recorded in a structured way.
 - Considering the least restrictive form of care
 - Helping the person retain contact with family / friends / carers / advocacy service support
 - Reviewing the care plan including an independent view e.g. advocacy service.
- 8.17 Copies of the COPDOL 11 application form and all the Care and Treatment Plans should be forwarded to the CCG's Designated Adult Nurse for Safeguarding. The Designated Adult Nurse for Safeguarding will check it and forward it to the CCG's Legal Advisors to progress to the Court of Protection.

8.18 Diagram to show the DoLS process for accommodation arrangements:



9. Monitoring and compliance

9.1 If someone wishes to challenge a lack of capacity finding, the following steps should be taken:

- Raise the issue with the person who carried out the assessment and ask for evidence to support their belief that the person lacks capacity. The assessor must show that he has applied the principles of the MCA 2005
- It may be possible to get a second opinion from an expert in assessing capacity
- If the disagreement cannot be resolved, the person who is challenging the assessment can apply to the Court of Protection who can rule whether the person has the capacity to make the decision in question.

9.2 To ensure CCG compliance with this policy the Continuing Healthcare Team with assistance from the Adult Designated Safeguarding Nurse will audit a sample of CHC cases to ensure that:

- mental capacity and best interest assessments are undertaken and recorded in line with MCA 2005
- referrals to the Independent Mental Capacity Advocate are being made in line with MCA 2005
- Deprivations of liberty for patients funded by continuing healthcare have been identified and authorised.
- that all CHC staff have relevant and current training in place.
- Staff competences are reviewed annually at staff's annual appraisals and the compliance to be reported on an annual basis.
- Compliance with safeguarding training is reported in the safeguarding annual report.

10. Education and Training

The CCG will provide relevant training to all employees according to the Royal College of Nursing (2018) 'Adult Safeguarding: Roles and Competencies for Health Care Staff'.

11. References

ADASS (updated 2016): London multi-agency Adult Safeguarding Policy and Procedures
<http://londonadass.org.uk/wp-content/uploads/2015/02/Pan-London-Updated-August-2016.pdf>

ADASS 'Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance'.
<http://londonadass.org.uk/wp-content/uploads/2014/12/MCA-commissioning-compliance-guide.pdf>

Mental Capacity Act 2007; Code of Practice
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Mental Capacity Act 2005: Deprivation of Liberty Safeguards

<https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards>

Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice

http://webarchive.nationalarchives.gov.uk/20110322122009/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Mental Capacity Act 2005: A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance NHS England 2014

<https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf>

Department of Health Guidance (2015): Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf

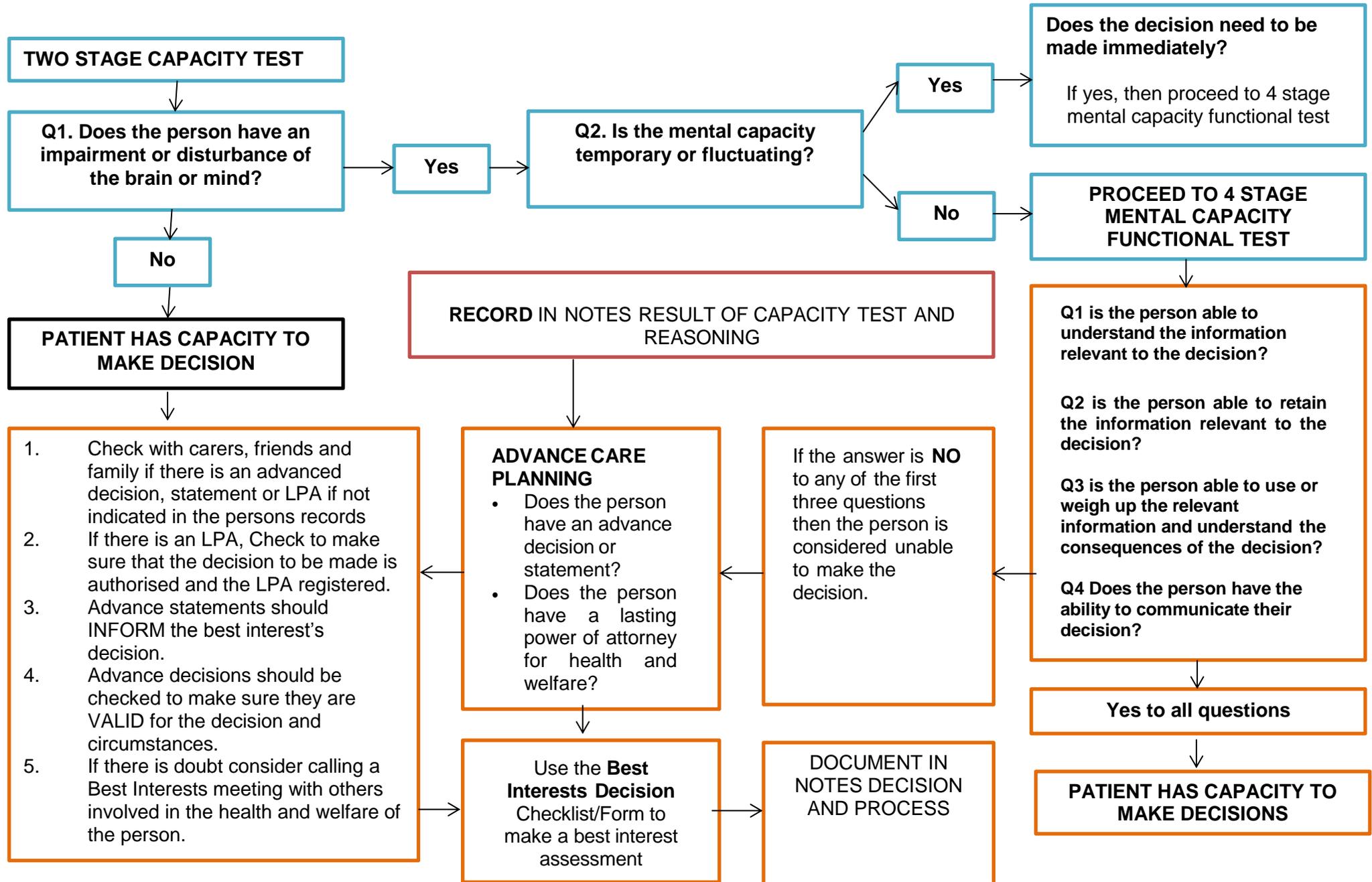
Royal College of Nursing (2018) 'Adult Safeguarding: Roles and Competencies for Health Care Staff'

<https://www.google.com/search?q=intercollegiate+guidance+on+Safeguarding+Adult+training&sourceid=ie7&rls=com.microsoft:en-GB:IE-Address&ie=&oe=>

Appendix 1: Equality Impact Assessment Form

Equality Impact Assessment Form	
Policy author: Eve McGrath	Date of assessment: 30/11/2018
Title of policy: Mental Capacity and Deprivation of Liberty Safeguards Policy	Is this a new or existing policy? New
1. Is there a concern that the policy does or could have a differential impact in any of the following areas?	
	Y/N – delete as appropriate
Age	No
Marriage/civil partnership	No
Disability	No
Religion/beliefs	No
Gender	No
Race	No
Pregnancy/maternity	No
Sexual orientation	No
Gender re-assignment	No
2. If the answer is 'no' for the groups above, please sign and date the form and add this form to the end of the policy.	
3. If the answer is 'yes' for any of the groups above, please explain the reasons and complete box 4 (below).	
4. Are there any additions or actions to be added to the policy which ensure the policy does not have an adverse impact on any of the protected groups? If the answer is "yes", please detail below.	
Policy author: Eve McGrath Adult Designated Nurse for Safeguarding (Interim)	Date: 30/11/2018
NHS Barking & Dagenham, Havering and Redbridge CCGs Ground Floor, Maritime House, 1 Linton Rd, Barking. IG11 8HG	Performance and Delivery Directorate: Nursing Quality and SafetyTeam Email: eve.mcgrath@nhs.net Tel: 020 3182 2923

Appendix 2 - Mental Capacity Act 2005 Pathway



Appendix 3: Deprivation of Liberty Pathway

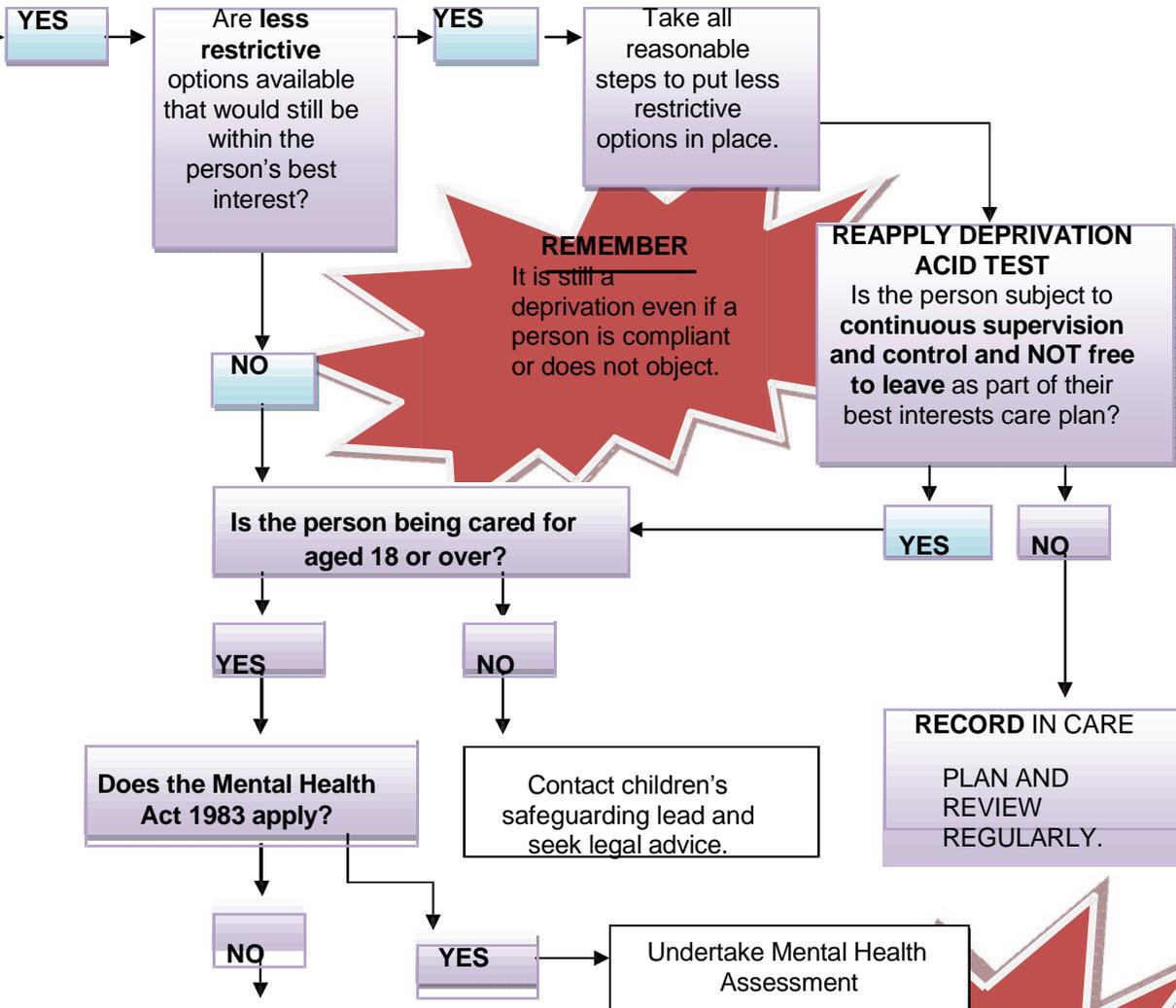
DEPRIVATION CHECKLIST
To be used when a person does not have capacity to consent to admission and/or care plan, and when there is a change of circumstances.

- Was restraint or sedatives used because the person resisted being admitted?
- Was the person misled to ensure they cooperated?
- Did anyone involved in the persons care and welfare object to the person being admitted?
- Is restraint being used when the person is expressing refusal or resistance to treatment other than in an emergency?
- Have relatives/carers requested the persons discharge into their care, and has this been refused?
- Has the person been refused or restricted access to friends and family?
- Does the care plan use the less restrictive options available in the person's best interests?
- Has the person's access to the community been restricted due to safety concerns?

Yes to any of the above would indicate that the person may be being deprived of their liberty.

- Is the person under continuous supervision and control?
- Is the person free to leave?

Yes to the above would indicate that the person is being deprived of their liberty in line with the 2014 Supreme Court Acid Test.



CONTACT YOUR LOCAL DoLS OFFICE

PATIENT may be DEPRIVED OF THEIR LIBERTY AND AN AUTHORISATION MUST BE SOUGHT.



Appendix 4 - Mental Capacity Assessment and Best Interest Decision Form

Name of practice:	Date completed:	Patient name:	
Name of person completing assessment:			
Signature of person completing assessment:	Date of birth:	NHS no:	
What triggered the capacity assessment?			
Stage 1: Diagnostic Test			
Q1 Does the person have an impairment of, or disturbance in the functioning of, the mind or brain?	YES	NO	
If the answer is "no" then the person cannot lack capacity within the meaning of the MCA. Please make a note in the patient record. If the answer is "yes" please answer all following questions			
Clinical diagnosis: Where the impairment or disturbance arises out of a specific diagnosis, please set out the diagnosis or diagnoses here.			
What is the decision that needs to be made?			

Is this impairment or disturbance:	Fluctuating	Permanent
Q2 If the person has fluctuating capacity does the decision need to be made immediately?	YES	NO
Please explain why:		
<p>Stage 2: Functional test</p>		
Q1 Does the person have a general understanding of the decision they need to make, why they need to make it and the likely consequences of making the decision (including the consequences of making no decision at all)?	YES	NO
Please give details:		
Q2 Is the person able to retain information relevant to the decision long enough to take it?	YES	NO
Please give details		

Q3 Is the person able to use or weigh information relevant to the decision, as part of the process of making the decision?	YES	NO
---	-----	----

Please give details

Q4 Can the person able to communicate their decision (by talking, using sign language, or any means at all)?	YES	NO
---	-----	----

Please give details

If the answer to any of these questions is NO, and this is caused by the impairment or disturbance you have identified, and your decision is on a balance of probabilities, the person lacks capacity to make this decision.

Advance Decisions

Has the person made a health and welfare lasting power of attorney which has been registered and gives the attorney(s) the authority to make the decision in question?	YES	NO
---	-----	----

Has the person made a valid, applicable advance decision to refuse the same treatment that this decision is about?	YES	NO
---	-----	----

Has a deputy been appointed by the Court with the power to make the decision in question?	YES	NO
--	-----	----

If you have answered “no” to all of the above, you may proceed with a best interests decision.

Best interests decision

Is an IMCA referral required? If there is no one to consult (other than paid staff) to support or represent the person, or to be consulted as part of the best interest decision process.

Name of IMCA:

Tel:

What are the options available as they relate to the decision in question? Please consider the positive and negative aspects of each option, and note which is less restrictive in terms of the person's rights and freedom of action.

Option 1

Option 2

Option 3

Have you identified and taken into account the person's past and present wishes and preferences, beliefs and values (including their treatment preferences): whether written or verbal?	YES	NO
What were these views?		
Have you consulted and taken into account the views of other interested parties (family, carers, friends, advocate, deputy or attorney)?	YES	NO
If yes, who was consulted and what was their view. <i>(please use additional space if necessary)</i>		
Have the views of other professionals involved in the person's care been consulted.	YES	NO
Please give details:		

Which option have you decided is in the person's best interests, and why (please record the decision clearly here)?

Please describe how your decision reflects the less restrictive principle?

Was there disagreement in reaching this decision? If yes, please give details and describe what actions are being taken to seek resolution.

Has every option been explored in communicating this decision to the person?	YES	NO
Date of decision	Date of review	Date of amendment
Have the practice records been updated?	YES	NO