NHS
North Cumbria
Clinical Commissioning Group

Mental Capacity Act
and
Court of Protection/Deprivation of Liberty Safeguards Policy

October 2017

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1 Introduction

For the purposes of this policy, NHS North Cumbria Clinical Commissioning Group (CCG) will be referred to as "the CCG".

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The CCG, as a member of the local Safeguarding Adults Board, Local Adult Safeguarding Sub Groups and Local Executive Groups has formally adopted the principles of the Safeguarding Adults Inter-Agency Policy and Procedures which references the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

This policy should be read in conjunction with the

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

Deprivation of Liberty Safeguards (DoLS): Code of Practice
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Deprivation of Liberty Safeguard Policy. Covering domestic deprivations of Liberty. http://www.southtynesideccg.nhs.uk/publications/policies/

Safeguarding Adults Policy CCG
http://www.northcumbriaccg.nhs.uk/about-us/safeguarding/PDFs/Useful-Documents/safeguarding-children-and-adults-at-risk-policy---jan-2017.pdf

2 Purpose and scope

The purpose of this policy is to support the CCG in discharging its duties and responsibilities as a commissioner. This requires the CCG to understand and be able to apply the principles of the Mental Capacity Act (MCA) 2005 Code of Practice, and Deprivation of Liberty Safeguards (DoLS) Code of Practice, so they can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests. Commissioned services are expected to demonstrate compliance with both Codes of practice and any legal changes as a result of case law.

The MCA applies to all people over the age of 16 across England and Wales, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment (ADRT) and being authorised under the Deprivation of Liberty Safeguards; in these situations the Act applies when a person is aged 18 or over.

The Act also introduces a number of bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate
- The Office of the Public Guardian
- The Court of Protection
- Advance Decisions to refuse treatment
- Lasting Powers of Attorneys

The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that practitioners:

- Observe the principles of the MCA
- Make assessment of capacity and it is reasonably believed that the person lacks capacity in relation to the matter in question
- A reasonable belief the action taken is in the best interests of the person

This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff.

All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

3. Governance and Accountability

The CCG Governing Body is responsible for making certain all its provider services have arrangements in place to meet their statutory requirements as well as setting contract standards, and monitoring that these are being complied with. Provider management will seek assurance via their appropriate internal governance arrangements. The CCG governing body through its governance structures will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DOLs

- Quarterly
- Annual reports

The CCG will ensure effective leadership, commissioning and governance through the following:

- Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and that CCG commissioning, contracting, contract monitoring and quality assurance processes fully reflects this.
- MCA and DoLS is an agenda item within Safeguarding, on the provider services' Quality Review Groups (QRGs).
- Ensuring service specifications, invitations to tender and service contracts fully reflect MCA and MCA DoLS requirements as outlined in this policy with specific reference to the clear standards for service delivery.
- Ensuring a system is in place for escalating risks via Risk Registers and QRGs

4. CCG Service Contracts and expected Standards

The CCG will ensure clear service standards for ensuring compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). These will be included in NHS commissioned services contracts, as appropriate to the service.

The CCG will seek assurance from providers in relation to these standards via its contract monitoring and quality assurance processes.

5. Implementation

All staff, including temporary and agency staff are responsible for actively cooperating in the application of this policy to enable the CCG to discharge its legal obligations and in particular;

- Comply with the MCA and DoLS Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.

- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager
- Complete mandatory MCA and DoLS training as required for their role

All managers are responsible for ensuring that relevant staff within the CCG (and NECS who have been commissioned to discharge a number of CCG key functions) have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. Training Implications

The training required to comply with this policy are:

- Policy awareness sessions
- Mandatory training programme
- E-learning
- Bespoke training provided/facilitated by CCG Safeguarding Team as required.

7. Definitions and practice explanations

The Following Terms are used in the document

Reference	**Abbreviated Term**
Advance Decision to refuse treatment	ADRT
Best Interests Assessor	BIA
Court of Protection	CoP
Deprivation of Liberty	DOL
Enduring Power of Attorney	EPA
General Practitioner	GP
Independent Mental Capacity Advocate	IMCA
Lasting Power of Attorney	LPA
Managing Authority (Hospital)	MA
Mental Capacity Act	MCA

Lack of Mental Capacity

'A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain'. [MCA section 2(1)]

An impairment or disturbance in the brain could be as a result of a diagnosis or condition such as (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A cognitive or neurological condition
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- A substance misuse

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. Someone must be supported to make decisions whenever possible.

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 various periods.

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.

Lack of Capacity must be established following the functional test and any subsequent decision or intervention made within the best interests' framework as set out in the MCA 2005

Mental Capacity Act (MCA) Principles

Underpinning the MCA are five guiding statutory principles. These must underpin commissioning intentions, plans, procurement and monitoring arrangements to ensure that services meet the needs of a range of adults in a way which promotes their rights, autonomy and independence whilst striking a balance with protection where necessary.

These guiding principles are the heart of any interaction with adults and can act as a benchmark for compliant MCA practice.

Principle one: Assumption of capacity

This means that everyone from the age of 16 is assumed to have mental capacity unless it is established that they lack capacity. Most important here is that the person does not have to prove

anything, the onus is on whoever doubts their mental capacity to prove that they are unable to make a particular decision.

Principle two: A person must not be assessed as lacking capacity unless all practicable steps have been taken to help them make the decision. This principle once again passes responsibility back to whomever doubts capacity to consider how the information is being presented and how the person is being supported.

Principle three: A person is not to be treated as unable to make a decision just because they make an unwise decision. This principle allows for people to make decisions others may view as eccentric even though they may have a mental impairment. It allows for everyone to have their own set of values and preferences, and to be unwise at times and to potentially learn from such decisions.

Principle four: Anything which is done for on behalf of someone who lacks capacity must be done in their best interests. This principle ensures an objective decision making process is used when acting on behalf of others. It ensures that the person's best interests (rather than those of, say, their relatives, or the commissioners of services) are the focus of this decision-making.

Principle five: When taking action or making a decision on behalf of someone who lacks capacity thought must always be given to whether this could be achieved in a way which is less restrictive of the person's rights and freedom of action. This principle ensures that a person's liberty and freedom of choice are not restricted thoughtlessly in order to achieve the necessary outcome.

Assessment of Lack of capacity

The evidence the Act requires to establish a lack of capacity is known as the 2 stage test that is both diagnostic and functional. Practitioners must set out their assessment and subsequent record, following this test.

Stage 1 Establishing if the disorder or impairment may affect the ability to make specific decision in question.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Stage 2 Assessing the ability to make specific decision

- Does the person have a general understanding of what decision they need to make and why they need to make it? Including the likely consequences of making, or not making, this decision?
- Is the person able to retain the information relevant to this decision?
- Is the person able to use and weigh up the information? Inability to do this must relate to the disorder or impairment and not a person's preferences or opinions such as cultural or religious views.

- Can the person communicate their decision by talking, using sign language or any other means? Would the services of a professional such as a speech and language therapist be helpful?

Where a decision is complex or more serious, a practitioner may consider there is a need for a more thorough assessment (perhaps by involving a doctor or other professional expert).

Making a best interest decision

One of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests. That is the same whether the person making the decision or acting is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional, and whether the decision is a minor issue – like what to wear – or a major issue, like whether to provide particular healthcare.

As long as these acts or decisions are in the best interests of the person who lacks capacity to make the decision for themselves or to consent to acts concerned with their care or treatment, then the decision-maker or carer will be protected from liability.

There are exceptions to this, including circumstances where a person has made an advance decision to refuse treatment and, in specific circumstances, the involvement of a person who lacks capacity in research. But otherwise the underpinning principle of the Act is that all acts and decisions should be made in the best interests of the person without capacity.

Working out what is in someone else's best interests may be difficult, and the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person's best interests. In some cases, there may be disagreement about what someone's best interests really are. As long as the person who acts or makes the decision has followed the steps to establish whether a person has capacity, and done everything they reasonably can to work out what someone's best interests are, the law should protect them.

What does 'decision-maker' mean in this policy?

The MCA does not lay down professional roles or require certain qualifications to undertake assessments. The capacity assessment should be done by the person who is proposing to undertake an action or make a decision. This person is the decision-maker and should follow the principles of the Mental Capacity Act and associated code of practice.

Who is the decision-maker?

Family members and informal carers will be decision-makers for actions that they undertake. A care assistant will be the decision-maker if the decision is, for instance, about what clothes to put on that morning. They would not be expected to complete a formal capacity assessment, but to have a

'reasonable belief' that the person lacks capacity for those decisions. (Code of Practice 4.44) (Part 24: MCA and family and informal carers) (Part 25: MCA and untrained workers)

Professionals are the decision-makers for actions they are responsible for. A doctor or other health professional will be the decision-maker about someone's capacity for the care and treatment they are prescribing, or initiating through a care pathway. A nurse will be the decision-maker about the treatment or care that they are delivering, administering or recommending. A social care professional will be the decision-maker about a move into residential care or commissioning a package of care.

This may mean that the decision-maker is not the person who knows the individual best. Determining who the decision-maker is depends on the decision and the context, and not on the circumstances of the individual.

If someone lacks capacity to make a decision for themselves all professionals will need to involve a person's family, friends, supporters, and an Independent Mental Capacity Advocate if appropriate, in the decision. The professional needs to have a genuinely open mind about the outcome of a decision. It may be appropriate to have a Best Interests Meeting to explore and record any differences

A public authority (local authority or health care trust) may have to make a decision which goes against a family view. The public authority must be able to show that any care they deliver is better for the person than the care the family want.

Involving other people

Many decisions will be multi-disciplinary in practice, but the decision-maker will be the person ultimately responsible for making/implementing and recording the decision.

A decision-maker must seek information from other people. For instance, a social worker making a decision about someone's capacity to decide about their care needs on discharge from hospital will seek information from family and friends, an IMCA (if appointed), ward staff, people who cared for the person in the community and anyone with knowledge of the person

Any decision-maker can seek advice from anyone else. It may be appropriate to consult a psychiatrist or psychologist, speech and language therapist or other specialist.

Anyone making an assessment should seek information about how the person is best able to communicate and how their understanding can best be enhanced. Family and friends are likely to be able to give this information.

If there is no one who can be consulted about the decision who is not paid to provide care, and no family or friends, the person is described as 'un-befriended'. For significant decisions, defined as a change in accommodation, serious medical treatment or an extended stay in hospital or residential care the person should be referred for a report from an Independent Mental Capacity Advocate (IMCA). The IMCA will provide a report about the person's situation and views: they will not make the decision and the decision-maker retains their responsibility.

Clinical Interventions in a person's best interests

Provided you have complied with the MCA in assessing capacity and acting in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Surgical procedures
- Admission to hospital for assessment or treatment with the exception of people requiring detention under the Mental Health Act 2007 (MHA)
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay.
- Placements in residential care

However, certain decisions are outside of the framework of best interests in the MCA and they may require the Court of Protection to make the particular decision. Sections 27-29 and 62 of the MCA set out such decisions. These include:

- Decisions concerning family relationships (section 27) e.g. consenting to sexual relations, consent to marriage, divorce, a child being placed for adoption or the making of an adoption order.
- Mental Health Act matters e.g. treatment under Part 4 the Mental Health Act 1983 amended 2007
- Voting rights (section 29)
- Unlawful killing or assisted suicide (section 62

The Independent Mental Capacity Advocate (IMCA)

Advocacy is taking action to help people:

- Express their views
- Secure their rights
- Have their interests represented
- Access information and services
- Explore choices and options

Advocacy promotes equality, social justice and social inclusion. Therefore an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

The MCA sets a requirement of statutory Independent Mental Capacity Advocacy (IMCA) and aims to provide independent safeguards for people who lack capacity to make certain important decisions and have no-one else other than paid staff to support or represent them or be consulted.

An IMCA must be instructed when:

- An NHS body is proposing to provide serious medical treatment.
- An NHS body or local authority is proposing to arrange accommodation or a change of accommodation, in a hospital or a care home and the person will stay in hospital for more than 28 days or 8 weeks in a care home.

An IMCA may be instructed

- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA MUST be instructed PRIOR to the decision being made. The only exception to this is when an urgent decision is needed, for example to save a person's life. This decision must be recorded with the reason for non-referral. The IMCA will still need to be instructed for any serious medical treatment that follows the emergency treatment and a decision maker must continue to act in a person's best interests whilst waiting the IMCA report, for example, providing treatment that stops a condition getting worse.

It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker. The decision maker has a duty to consider the IMCA report but remains the decision maker.

Information on local IMCA providers is available from the Local Authority or the CCG.

Advance Decisions to Refuse Treatment (ADRT)

People with capacity over the age of 18 years, are able to make advance decisions regarding refusal of health treatments, which will relate mainly to medical decisions, these should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.

Making an advance decision to refuse treatment allows particular types of treatment you would never want, to be honored in the event of losing capacity – this is legally binding and health care professionals must follow ADRT when found to be valid and applicable.

Practitioners must take all reasonable efforts to check if and advance decision exists, and that it is valid and applicable to the particular treatment in question. Reasonable steps would include, checking the records, asking the patient, their friends or family, and checking with the GP if one is known or recorded. Reasonable steps are dependent on the urgency and nature of the treatment in question.

The Act introduces a number of rules you must follow. Therefore a person making an ADRT should check that their current advance decision meets the rules if it is to take effect.

An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive, which without they may die) this must be in writing.

Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. A person cannot ask for an advance decision to end their life or request treatment in future.

The validity of an advance decision may be challenged on the following grounds;

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act if the criteria for this are met.
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision

Advance statements of preference

Advance statements of preference are evidence of a person's wishes and preferences regarding care and treatment. Unlike ADRT's they are not legally binding however should be considered by the practitioner in decisions of best interest. They are evidence of the persons wishes and feelings and may provide a clear indication of what the person would have wished for when capacitated to make the relevant decision for themselves. Statements

of preference often form part of anticipatory care planning, treatment escalation plans and end of life care planning.

Lasting Powers of Attorney (LPA)

This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters
- Personal Welfare LPA re decisions about health and welfare, where you live, day to day care or medical treatment.

This must be recorded in the person's file where there is knowledge of it. It must be registered with the Office of the Public Guardian to take effect and an LPA can only act within the remit of the authority set out in the LPA. For example, A LPA for property and affairs does not give authority for Health and welfare decisions and a Health and Welfare LPA only covers life sustaining decisions if explicitly set out to do so.

Important facts about LPAs

- Enduring Powers of Attorney (EPAs) can no longer be made after 2007 and they
- Only apply to financial matters.
- When a person makes an LPA they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has a welfare LPA, the attorney will be the decision maker on matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.
- The Office of the Public Guardian (OPG)

This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the COP, as requested.

The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. This is a free service.

Further information regarding the Office of the Public Guardian including all the forms to make powers of Attorney, can be found by the following link: http://www.publicguardian.gov.uk/

The Court of Protection (COP)

This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

The Act provides for a COP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (i.e. set examples to follow in future cases).

The Court of Protection has the powers to:

- Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- Appoint deputies to make decisions for people lacking capacity to make those decisions;
- Decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties,
- and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.

Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website.

The CCG must be assured that all informal and formal internal mechanisms have been exhausted before making any application to the Court of Protection. However where an application is required, this must not be delayed

Deprivation of Liberty Safeguards

Whilst a Deprivation of Liberty (DoL) may occur in any care setting, the DoL safeguards (DoLS) form part of the MCA and provide legal protection for people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements. Those affected by the DoLS will include people with a "mental disorder", as defined within the Mental Health Act (1983) amended (2007), who lack the capacity to make informed decisions about arrangements for their care or treatment. The DoLS clarify that a person may be deprived of their liberty:

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- it is in their own best interests to protect them from harm.

On 1st April 2013, Primary Care Trusts ceased to exist and their Supervisory Body (SB) role was transferred to Local Authorities (LA). As such the CCG's are not Supervisory Bodies (SBs) but they are required to work closely with providers and the LA's to ensure the protections offered by the safeguards are implemented appropriately and that care they commission is compliant with the MCA and DoLS.

Implications of the Cheshire West court ruling

The Supreme Court ruling in the P 'v' Cheshire West and Chester Council and P & Q 'v' Surrey County Council cases has far reaching implications for the CCG. Although CCGs are no longer Supervisory Bodies, the lowering of the threshold has meant there are significant responsibilities for the CCGs to ensure any deprivation occurring outside of a hospital or care home is properly reviewed and where necessary the appropriate actions are taken to negate the deprivation or to authorise it.

Where a CCG employee or representative, in performing their duties, feels a deprivation of liberty is occurring (See section on 'acid test' above) then they need to take account of the setting in which care is being delivered.

If the care is in a hospital or care home setting then the CCG employee or representative should ask the Managing Authority to make an application for authorisation under Deprivation of Liberty Safeguards to the appropriate Supervisory Body.

Where the CCG employee or representative feels the Managing Authority are not acting on their concerns they should contact the Supervisory Body to ask them to consider a 'third party' application.

Where the CCG employee or representative recognises that a potential deprivation of liberty may be occurring in a community setting; such as an Independent living scheme, a person's own home, an Adult placement or Foster placement, then the following process should be followed:

- Review the care package to see if any restrictions could be removed to negate a deprivation.
- CCG or NECS staff, such as those responsible for commissioning or reviewing the care package must make and record an assessment of the person's mental capacity to consent to their care (Appendices 1).
- Where an individual lacks the mental capacity to consent, then the assessor should apply the 'Acid Test' (see above), i.e., is the person subject to continuous supervision and control and not free to leave and live elsewhere?
- Is there care 'Imputable to the state', i.e., is it arranged and/or funded by a government body such as CCG, NECS or Local Authority. Where packages are joint funded, then discussion should be held with the relevant Supervisory Body about whether an application to the Court of Protection is needed to authorise the deprivation of liberty.
- Where the care package is entirely health funded, then legal advice should be sought from the CCG's DoLS/MCA lead and/or the CCG legal advisors as to whether an application to the Court of Protection for authorisation is necessary.
- Where it is decided that an application needs to be made, the responsible assessing officer or case manager needs to compile evidence for the Court application on advice of the CCG solicitor.

A less obvious consequence of the 'Cheshire West' ruling is that the number of people detained under the Mental Health Act 1983 will also rise. This has implications for the CCG it terms of the numbers of people entitled to Section 117 aftercare will rise. The impact this has on budgets should be monitored.

Any unauthorised Deprivations will carry with it a potential risk of litigation. Such a risk should be included on the risk register and an action plan to address the risk reviewed on a monthly basis

8. Legislation and statutory requirements

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- P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190

9. Best practice recommendations

- Department of Health. (2006) *Records Management: NHS Code of Practice.* London: DH.
- NHS Litigation Authority. (2008) *Risk Management Standard for Primary Care Trusts.* London: NHSLA.
- HM Government (June 2014) Valuing Every Voice, respecting every right: Making the Case for the Mental Capacity Act. The Government's response to the House of Lords Select Committee report on the Mental Capacity Act 2005. Lord Chancellor and Secretary of State for Justice and Secretary of State for Health
- Independent Safeguarding Authority (http://www.isa-gov.org.uk/)
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Summary of Key Points

Managing Authorities – (Care Homes & Hospitals):-

• need to adapt their care planning processes to incorporate consideration of whether a person has capacity to consent to the services which are to be provided and whether their actions are likely to result in a deprivation of liberty.

• must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation has been given by the Supervisory Body.

• requests a standard authorisation and implement the outcomes.

• should obtain from the Supervisory Body in advance of the DOL, except in circumstances considered to be so urgent that the DOL needs to begin immediately. In such cases, authorisation must be obtained within seven calendar days of the start of the DOL.

• must ensure that they comply with any conditions attached to the authorisation.

• should monitor whether the RPR maintains regular contact with the person.

• should only request standard authorisation if it is genuinely necessary for a person to be deprived of liberty in their best interests in order to keep them safe.

Supervisory Bodies – (Local Authorities):-

• will receive applications from Managing Authorities for standard authorisations.

• must have obtained written assessments of the relevant person in order to ensure that they meet the qualifying requirements.

• need to ensure that sufficient skilled assessors are available.

• may not give authorisation unless all the qualifying requirements are met.

• must specify an authorisation's duration, which may not exceed 12 months.

• may attach conditions to the authorisation if it considers it appropriate to do so.

• must give notice of its decision in writing to specified people, and notify others.

• must appoint a Relevant Person's Representative to represent the interests of every person for whom they give a standard authorisation for DoL. CCG CO03 Deprivation of Liberty Safeguards (DoL) Policy 17

In addition, both MA and SB should be aware of the following key points:

• An authorisation may last for a maximum period of 12 months.

• Anyone engaged in caring for the person, anyone named by them as a person to consult, and anyone with an interest in the person's welfare must be consulted in decision-making.

• Before the current authorisation expires, the Managing Authority may seek a fresh authorisation for up to another 12 months. Provided the requirements continue to be met.

• The authorisation should be reviewed, and if appropriate revoked, before it expires if there has been a significant change in the person's circumstances.

• When an authorisation is in force, the relevant person, the RPR and any IMCA representing the individual have a right at any time to request that the Supervisory Body reviews the authorisation.

• A decision to deprive a person of liberty may be challenged by the relevant person, or by the RPR, by an application to the CoP. However, Managing Authorities and Supervisory Bodies should always be prepared to try to resolve disputes locally and informally.

• If the court is asked to decide on a case where there is a question about whether DoL is lawful or should continue to be authorised, the Managing Authority can continue with its current care regime where it is necessary: – for the purpose of giving the person life-sustaining treatment, or – to prevent a serious deterioration in their condition while the court makes its decision.

• Management information should be recorded and retained, and used to measure the effectiveness of the DoL processes. This information will also need to be shared with the inspection bodies. CCG CO03 Deprivation of Liberty Safeguards (DoL) Policy 18

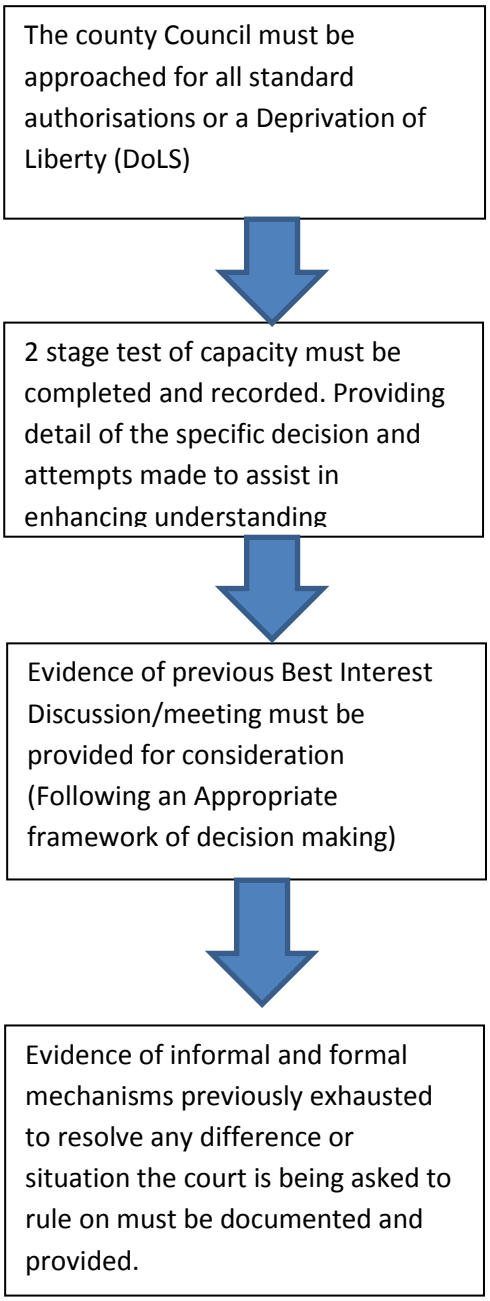
Additional Point for CCGs where deprivation occurs outside of the DoL Safeguards

- Where possible gain consent for care packages from the relevant person
- Where there is doubt, assess mental capacity and make a formal record on MCA 1
- Review the package to see if it can be made less restrictive without compromising the safety of the relevant person.
- Hold a Best Interest Meeting to determine if the overall package meets the 'Acid Test' then seek legal advice regarding an application to the Court of Protection or whether there are other legal remedies, ie Mental Health Act 1983 if treatment is for a mental disorder and patient is objecting
- Funding for joint packages for any legal processes should be agreed with the Local Authority
- Fully funded packages of care will require CCG funding for Court Applications.

CCG should seek assurance from providers via Contract Monitoring of the following:

- There is a free standing section covering DoLS in Providers' MCA policy or a separate DoLS policy linked to their MCA policy.
- There is separate DoLS Training.
- Care plans highlight areas of restriction and restraint and show consideration of the DoLS criteria and process.
- Ensure provider staff have access to DoLS forms and are, are trained in completing them and are aware of how to process them.
- DoLS are reflected in audit and internal review programmes.
- Evidence the hospital has developed clear links with the local Supervisory Body DoLS service.
- Providers are aware of their responsibilities to notify CQC of DoLS activity.
- DoLS is considered in reports regarding the care and treatment of vulnerable patients such as those with learning disabilities, dementia, mental illness, stroke and traumatic brain injury.
- Ensure provider staff have access to Codes of practice and are kept up to date with significant case-law by their own legal advisors.

Process for consideration when use of the Court of Protection is required



Early conversation with the CCG Lead for MCA/Court of Protection must be had to alert the CCG of the above activity. Once all the above have been exhausted/completed then the CCG will seek legal support to present the case to the Court of Protection

MENTAL CAPACITY ASSESSMENT RECORD

NB:- Practice Guidance attached at end of document	**Write patient details or affix Identification label** Name: Address: Postcode: Date of Birth: NHS Number:
Abbreviations used in this document to be listed here with the full description: **IMCA**-Independent Mental Capacity Advocate **NHS**- National Health Service	
GPs Name:	

This form must be used for capacity assessments and best interest decisions in relation to:-

- Necessary medical treatment
- Safeguarding procedures

Date of Assessment:	**Time:** (24 hour)
Assessment Completed By:	
Name:	

Job Title:
Department/Organisation and Location
Details description of specific decision to be made: Including the specific question to be asked of the service user/patient and the language used:

The following steps have been taken to enhance the persons understanding. **Please describe below:**

2. STAGE TEST OF CAPACITY	
Does the service user/patient: **a) Have an impairment of the mind or brain or is there some sort of disturbance affecting the way their brain works?** (it doesn't matter whether the impairment or disturbance is permanent or temporary)	**Yes** ☐ **No** ☐
1 or more negatives in section b (below) indicates a lack of capacity to make this decision	
b) Is the service user/patient able to:	

• Understand the question?	**Yes** ☐ **No** ☐
Please provide the evidence:	
• Retain the information?	**Yes** ☐ **No** ☐
Please provide evidence:	
• Use and weigh up the information relevant to the decision?	

	Yes ☐ **No** ☐
Please provide the evidence:	
• Can the service user/patient communicate their decision by talking, using sign language or by any other means?	**Yes** ☐ **No** ☐
Please provide the evidence:	
c) To aid communication, would the services of a professional be helpful. (Consider a Speech and language Therapist, Dementia or Learning Disability Specialist services)	**Yes** ☐ **No** ☐

Please provide evidence:	
Is there need for a more specialist assessment (i.e. Mental Health Assessment? Please provide evidence and record actions taken:	**Yes** ☐ **No** ☐
I consider the service user/patient **Has** ☐ **Does not have** ☐ Capacity to make this decision due to:- (please provide a concluding and summarising statement)	

See 'Best Interest Decision' making document for how to approach and record the actions to be taken relating to the decision that triggered this capacity assessment.
Signed:
Name:
Job Title:
If the service user/patient is assessed as not having capacity to make this decision, you must consider the best interests checklist before deciding what is in the service user/patients best interests.
Any additional Information:

BEST INTEREST CHECKLIST

MENTAL CAPACITY ASSESSMENT RECORD

GUIDANCE NOTES

Introduction

The Mental Capacity Act came into effect in April 2007 and anyone acting in a professional capacity for, or in relation to, a person who lacks capacity, are placed under a duty to have regard to its Code of Practice. In order to ensure that a consistent and thorough approach is given to the requirements within the Code, this record of a Mental Capacity Assessment has been developed, which includes the 2 stage test of capacity and a following Best Interest checklist.

Using the Assessment Record

Where there are doubts around a person's ability to make a particular decision for them-self the Assessment Record **must** be used to assess capacity and, where necessary, make a best interest decision on that persons behalf:

- Necessary medical treatment
- Safeguarding Adults procedures

(Please refer to the Mental Capacity Act Code of practice if further details on these areas are required)

When completing the Assessment record, it is important to ensure that the information stated is as it was presented to the service user i.e. use the terminology/layman terms used when explaining the options available to them.

Completed Assessment records should be stored within the relevant person's file.

Statutory Principles

There are 5 statutory principles of the Mental Capacity Act. These are:

1. A Person must be assumed to have the capacity unless it has been established that they lack capacity to make that particular decision.
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.
3. A person is not to be treated as unable to make a decision merely because they make an unwise one.
4. An act done or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in their best interests.
5. Before the act is done or the decision made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

When should capacity be assessed?

Capacity should be assessed when:

- The persons behaviour or circumstances cause doubts as to whether they have capacity to make a particular decision
- Somebody else says they are concerned about the persons capacity

Or

- The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown that they lack capacity to make other decision in their life

The starting assumption must be that the person has the capacity to make specific decision. If, however, anyone thinks a person lacks capacity, it is important to then ask them the following questions:

- Does the person have all the relevant information they need to make the decision?
- If they are making a decision that involves choosing between alternatives, do they have information on all the different options?
- Would the person have a better understanding if the information was explained or presented in another way?
- Are there times of the day when the person's understanding is better?
- Are there locations where they may feel more at ease?
- Can the decision be put off until the circumstances are different and the person concerned may be able to make the decision? E.g. if they have fluctuating capacity, can the decision wait until the capacity has retuned so they can make the decision for themselves)
- Can anyone else help the person to make choices or express a view? (e.g. family member or carer, advocate or someone to help with communication)

If all practicable and appropriate steps fail, an assessment of the person's capacity to make that particular decision will be needed.

Who Assesses capacity?

The person who assesses an individual's capacity to make a particular decision will usually be the person who is directly concerned with the individual at the time when the decision needs to be made. This means that different people will be involved in assessing a person's capacity to make different decisions at different times.

For most day to day decisions, this will be the person caring for them at the time a decision has to be made.

For example, a care worker might need to assess if the person can agree to being bathed. Then a Nurse might need to assess if the person can consent to having a wound dressing being changed.

- For acts of care or treatment, the assessor must have reasonable belief that the person lacks capacity to agree to the action or decision taken
- If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent
- More complex decisions are likely to need more formal assessments. A professional opinion on the person's capacity to make the particular decision may be necessary. This could, for example, come from a psychiatrist, psychologist, speech and language therapist, occupational therapist or social worker. But the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity – not the professional, who is there to advise only
- Any assessor should have the skills and ability to communicate effectively with the person. If necessary, they should get professional help to communicate with the person.

Further information

Further information on the Mental Capacity Act is available on your intranet or from the following website: www.dh.gov.uk

Best Interest Decision Form

Embedding in to practice the philosophy of *"Make no decision about me without me"*

Section 1. Information about the Adult:		
Name of adult:		NHS Number:
Date of Birth:		Sex: ☐ Female ☐ Male
Address:		Post Code:
Tel.no:		Mobile Number:
Ethnicity:		First Language:
GP details, including address and contact number:		
Does the person have a nominated representative or advocate? If so who	Name: :	
Has the person's representative been contacted?	☐ Yes ☐ No If no, why not?	
Are they willing to engage in the decision making process	☐ Yes ☐ No If no, why not?	

Section 1a. Legal Powers of others to act on behalf of the adult:

If you answer yes to any of the questions 3a – 3f below, you must ask to see original documents to check their validity. If the documents aren't available, telephone the Office of the Public Guardian (OPG) to check. If the decision is urgent, there is no need to wait to see the documents – but the person's representative must be made aware that documents will need to be verified after the event. Make the person's representative aware that providing misleading information, or misusing legal powers, may result in arrest and prosecution.

3a) Does the person have an old Enduring Power of Attorney ? (this will only become ***effective only after the person has been assessed as lacking capacity*** to make decisions **about their property or finances**)	☐ Yes ☐ No ☐ Don't know If yes, tell us about the person here: Name: Relationship: Contact details:
3b) Does the person have a new Lasting Power of Attorney for Finances/Property? (**can be activated before loss of capacity**)	☐ Yes ☐ No ☐ Don't know If yes, tell us about the person here: Name: Relationship: Contact details:
3c) Does the person have a new Lasting Power of Attorney for Health & Welfare? (***effective only after the person has been assessed as lacking capacity*** to make specific decisions **about health and/or welfare**)	☐ Yes ☐ No ☐ Don't know If yes, tell us about the person here: Name: Relationship: Contact details:

3d) Does the person have a legal **Advance Decision to refuse medical treatment**? (Explicit, witnessed, dated and signed)	☐ Yes ☐ No ☐ Don't know If yes, is a copy available? ☐ Yes ☐ No (a copy will need to be seen)
3e) Does the person have a **Court Appointed Deputy**?	☐ Yes ☐ No ☐ Don't know If yes, tell us about the person here: Name: Relationship: Contact details:
3f) Is the person subject to an existing **Guardianship Order** as defined under section 7 of the Mental Health Act	☐ Yes ☐ No ☐ Don't know If yes, tell us about the person here: Name: Relationship: Contact details:

Section 2. What is the decision to be made in the persons best interest?

Please tell us the specific decision here:	

Section 2a. Regaining capacity

Is it likely that the person will regain capacity?	☐ Yes ☐ No *If you have answered yes to this question, can the decision wait until the person regains capacity? If yes, then wait!* *If not then please tell us why in the box below, then continue with the process:*

Section 2b. Least Restrictive Option

Is this the least restrictive option for the person?	☐ Yes If this is the least restrictive option, please tell us why below:

	☐ No If it is not the least restrictive option, please tell us why below:

Section 3. Independent Mental Capacity Advocates (IMCA)

If the person is unbefriended, meaning they have no nominated representative and there is nobody willing to act as such or the nominated representative does not want to be part of the decision making process (but is not objecting to it) or the person's nominated representative is alleged to have harmed, exploited or abused the person you should appoint an IMCA.

For local advocacy services please follow link to People First Cumbria: -

http://www.peoplefirstcumbria.org.uk/

Does the person require an IMCA	☐ Yes ☐ No
If yes, tell us why here:	
Date and time IMCA requested	Date: Time:

Section 4. Tell us here about other people consulted as part of this decision making process – not every decision requires a meeting!

The people listed below: where consulted as part of a discussion ☐ Attended a best interest meeting ☐

Person 1:		Role/Representing:	Contact number
e-mail			

	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 2		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 3.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 4		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 5.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			

Person 6.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 7.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 8.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 9.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		
What did they say?			
Person 10.		Role/Representing:	Contact number
e-mail			
	☐ Consulted ☐ Invited ☐ Attended ☐ Apologies		

What did they say?	

Section 5.

Question 1

What is the justification for the proposed care, treatment, decision or action?	

Question 2

Are there any risks relating to proposed care, treatment or decision?	

Question 3

Are there any risks related to not carrying out the proposed care, treatment or decision?	

Question 4

Are the persons past or present wishes/feelings regarding the treatment or decision known?	

Question 5

Are there any beliefs and or values that would be likely to influence the decision, if he/she had the capacity?	

Question 6

What are the views of the other, relevant people in the person's life?	

Question 7

Are there any disputes between any party about what is in the persons best interests?	☐ No, proceed with Best Interest Decision ☐ Yes, a decision will need to be made by the Best Interest Assessor (the person completing this form) whether the decision can be delayed or whether action needs to be taken at once, key considerations are relief of pain, protection from harm/abuse or exploitation and the preservation of life . Please tell us here the nature of the dispute:

	Dispute resolution should be mediated and chaired as follows: Local dispute resolution meeting chaired by the local Designated Nurse for Safeguarding & Vulnerable Adults or a Named Lead Safeguarding Professional. Where local dispute resolution fails, the matter can be referred to the Court of Protection for a judgement. NB: The party that refers to the Court of Protection are usually liable for the costs of the case.

Section 6. Outcome of Best Interest discussion/meeting	
Please tell us the outcome of your discussions here and reasonable beliefs with regard to Best Interests:	

Where the Court of Protection is not involved professionals, carers, relatives and others can only be expected to have reasonable grounds for believing that what they are doing, or deciding, is in the best interests of the person concerned. They must be able to demonstrate objective reasons as to why they believe they are acting in the person's best interests and they must have considered all relevant circumstances.

Section 7. Declaration	
I, the undersigned, believe this to be a fair representation of the discussions that took place. Those consulted agree that we have reasonable grounds for believing that what we are doing, or deciding, is in the best interests of the person concerned at this point in time.	
Name of person completing this document:	
Job title of person completing this document	
Contact details of person completing this document	
Date document completed	

Whilst a Deprivation of Liberty may occur in any care setting, the Deprivation of Liberty (DoL) safeguards provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements. Those affected by the DOL safeguards will include people with a "mental disorder", as defined within the Mental Health Act 2007, who lack the capacity to make informed decisions about arrangements for their care or treatment, a risk that the person may be deprived of their liberty must be identified.

The DoL safeguards clarify that a person may be deprived of their liberty:

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- It is in their own best interests to protect them from harm, and;
- If it is a proportionate response to the likelihood and seriousness of the harm, and;

- It is the least restrictive way of meeting their needs safely.

CCG's are not Supervisory Bodies as defined in the Mental Capacity Act however there is a clear expectation that CCG's work closely with providers and the Local Authorities to ensure the protections offered by the safeguards are implemented appropriately.

On 19th March 2014, the Supreme Court published its' judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases.

This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an 'Acid Test'. In doing so, they have significantly reduced the threshold and significantly widen the scope of whom may be affected to cover Independent Living Schemes, Adult Placements, Children's Foster Placements and potentially even people at home receiving CHC funded packages of care.

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorised obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), The Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (COP). CCGs should be able to seek assurance from providers that they are compliant with the DoLS framework.