NHS Wandsworth and Merton Clinical Commissioning Group and GP Member Practices

Mental Capacity Act Policy and Deprivation of Liberty Safeguards

Document control

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1.0 Introduction

1.1 The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves. It contains provisions for assessing a person’s mental capacity to make decisions and also outlines procedures for acting on behalf of people who may lack mental capacity. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of a person who lacks the capacity to make the decision or to act for themselves must be made in their best interests.

1.2 The MCA promotes empowerment for people who lack capacity to enable them to take part in the decision making process and promotes the human rights law which advocates the protection of individual rights.

1.3 The MCA is applicable to anyone aged 16 and over living in England and Wales and relates to both care and treatment of the person. The Code of Practice supports practitioners to implement the MCA within practice.

1.4 The MCA advocates five statutory principles which guide and inform the process of decision making to determine the best course of treatment and support for care provision in people who may lack capacity.

1.5 Everyone working with or caring for a person who may lack capacity to make a specific decision must comply with the principles as set out in the MCA, irrespective of whether the decision relates to a life changing event or an everyday matter.

2.0 Purpose of the policy

This policy details the roles and responsibilities of NHS Wandsworth and Merton CCG as a commissioning organisation, with respect to MCA issues and will also include guidance in relation to the Deprivation of Liberty Safeguards (DoLS) and how these fits in within the context of the MCA. It will also provide guidance for GP member practices in issues relating to the MCA and DoLS within the primary care sector.

The policy outlines the responsibilities and duties for practitioners to assist and support people to make decisions. If the person is not able to make the decision, the MCA clearly sets out the process of how capacity should be determined, the assessment and decision making process, and how any decisions made on behalf of the person should be in their best interest. This will include issues relating to the best interest assessment process and DoLS where identified. The policy will outline how to identify the DoLS process and when this should be used and who the best interest assessors will be to determine the needs of the person.

The other key focus is on practitioners understanding that just because a person cannot make one particular decision; this does not necessarily mean they will not be able to make the next.
3.0 Scope

When applying the MCA, certain categories of people are legally required to have regard to relevant guidance contained in the MCA code of practice.

These people include: “Anyone acting in a professional capacity for, or in relation to, a person who lacks capacity” and “Anyone being paid for acts for or in relation to a person who lacks capacity.”

This policy, therefore, applies to all staff directly employed by NHS Wandsworth and Merton CCG and GP member practices and will have implications for all commissioned services.

The policy aims to ensure that no act or omission by the CCG as commissioning organisation or GP member practices puts an adult without mental capacity at risk and that robust systems are in place to safeguard and promote the rights of adults without capacity in commissioned services.

Where the CCG is identified as the lead commissioner it will notify associate commissioners of a provider’s non-compliance with their responsibilities with respect to any serious untoward incidences that relates to mental capacity issues.

For GP member practices, it will provide guidance for practice staff in relation to the assessment process of mental capacity. The formal process of capacity assessment will be outlined along with key documentation that will have been used.

4.0 Definition of the Mental Capacity Act

4.1 The MCA defines lack of capacity in the following way: “a person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain.”

4.2 Capacity is decision specific, in other words assessing capacity refers to assessing a person’s ability to make a particular decision at a particular moment in time, rather than being a blanket judgement about a person’s ability to make decisions in general.

5.0 Basic Principles of the Mental Capacity Act

- **A presumption of capacity** – each adult is said to have the right to make decisions and an assumption that they have capacity must be advocated, unless stated otherwise.
- **Support individuals to make their own decisions** – the person will be provided with all the relevant support to make the decision before it can be concluded that the person is unable to make that decision.
- **Right to make an unwise decision** – it is every person’s fundamental right to make an unwise or erratic decision and that everyone’s beliefs and values, preferences should not be regarded as the same as everyone else’s. Making an unwise or erratic decision cannot be regarded as evidence of a lack of capacity.
• **Best interest** – all decisions made on behalf of a person that lacks capacity should be made in their best interests.
• **Least restrictive option** – all decisions made for the person who lacks capacity should incorporate interventions that are least restrictive.

6.0 Definition of Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were incorporated within the MCA and provide a protective legal framework to people at risk who may be deprived of their liberty and are not detained under the Mental Health Act 1983.

Under the Article 5 of the European Convention on Human Rights is everyone’s fundamental right to have “liberty and security….. No one shall be deprived of his liberty save… in accordance with a procedure prescribed in law.”

These safeguards are applicable to anyone aged 16 years old and above; residing in hospitals and care homes, irrespective of whether this is privately or publicly funded. The main purpose is to prevent decisions being made that do not reflect the person’s best interest, which may deprive them of their liberty. If deprivation of the person’s liberty is required, a process is followed, which takes into consideration the person’s rights, representation and any appeal process and how the authorisation will be monitored and reviewed as required.

If the person lives in their own home or supported living, the process of gaining authorisation is required and an application should be made to the Courts. Under the MCA, staff are given responsibilities to ensure that people at risk are cared for and treatment provided without compromising their health and wellbeing. Any restriction and restraint implemented must be done so with the full authorisation of the DoLS application from the relevant local authority or Courts as in the case of a Court of Protection. If this is not done and the person is deprived of their liberty without the appropriate process being complete; this will be unlawful.

6.1 Acid Test

• In 2014, the UK Supreme Court Ruling made a decision on what was regarded as the ‘Acid Test’ in relation to whether a deprivation is occurring. This applies to people who do not have the capacity to consent to their care and treatment: The criteria outlined the following:
  • (1) determine if the person is subject to continuous supervision and control
  • (2) whether the person is free to leave.

The implications of this for the CCG is to ensure that as part of their assurance process, any person in a care home, fully funded by the CCG, has evidence of care planning and systems in place that advocates care being implemented within the context of MCA/DoLS.

For any applications for Personal Health Budgets (PHB) for people living in their own homes, the CCG Commissioning team should ensure that issues around MCA/DoLS are included and explored with the adult safeguarding team as part of the PHB panel. For any person who may be identified as lacking capacity, there should be evidence of clear safeguards in place around MCA and Court of Protection, where application, prior to the PHB authorisation.
For GP member practices, it is about GP and practitioners recognising incidences where there may be a deprivation of liberty during consultation visits in care homes, supported living and people’s own home. This will enable them to intervene earlier and act upon this by making referrals to the relevant key individuals to consider whether an MCA needs to be explored and any DoLS/Court of Protection considered where applicable.

7.0 Various legislation and guidance relevant to this policy

The following key legislation and guidance are used in conjunction with the MCA policy and will need to be considered within the context of this legislation to determine what is in the person’s best interest.

- Mental Capacity Act 2005
- The Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice 2009
- The Mental Health Act 2003
- The Care Act 2014
- Care and Support Statutory Guidance
- The Human Rights Act 1998
- The European Convention on Human Rights
- The Children Act 1989

8.0 Governance and Accountability - CCG

NHS Wandsworth and Merton CCG has lead responsibility for Mental Capacity and DoLS within the health economy in Wandsworth and Merton, supported by the NHS England regional office.

NHS Wandsworth and Merton CCG has clear lines of accountability for mental capacity and DoLS that are reflected within CCG governance arrangements. The mental capacity and DoLS function sits within the Quality and Development Directorate. The Executive and Board leads for the Mental Capacity and DoLS is supported by designated adult safeguarding lead who provides both strategic and clinical leadership by participation in the work of the Health and Wellbeing Board and local safeguarding boards to embed mental capacity and DoLS at every level across the health community.

The governance systems will need to demonstrate that there is evidence of the MCA embedded within audit programmes. There should be evidence that the MCA is incorporated within the quality assurance processes, which relate to best interests decision-making and that this is monitored through audit and reviews. This aspect will demonstrate how staff are utilising the guidance as outlined in the MCA Code of Practice.

The Joint Health Safeguarding Subgroup supports both the Quality Committee and Wandsworth and Merton Safeguarding Adults Board to drive and monitor the effectiveness of mental capacity and DoLS arrangements across the local health economy. This subgroup is chaired by NHS Wandsworth and Merton CCG Executive Lead for Safeguarding (Managing Director) and includes representation from the Wandsworth and Merton Safeguarding Adult Board.
9.0 Responsibilities of NHS Wandsworth and Merton CCG and GP Member Practices

In order to discharge its responsibilities with respect to the Mental Capacity Act NHS Wandsworth and Merton CCG and GP member practices will:

- Ensure that the organisations from which it commissions services provide a safe system which safeguards adults and children (16-17 year old) at risk who lack mental capacity.
- Ensure it commissions MCA compliant care and where providers will meet their statutory responsibilities of people who lack capacity to consent to care and treatment.
- Ensure that all staff employed by them are aware of their responsibilities under the MCA and that they will operate at all times in accordance with the policy and the accompanying Code of Practice.
- Identify a named MCA lead and ensures that a relevant policy, procedures and organisational structures support their role as the lead. GP practice safeguarding lead will also act as a lead in MCA.
- Ensure that all relevant staff are aware of their responsibilities with respect to the MCA and that CCG staff and member practices operate at all times in compliance with the act and the accompanying code of practice.
- Ensure that training with regard to the mental capacity act and effective implementation is provided to relevant staff.
- Engage with local Safeguarding Adults Board (SAB) and board sub-groups.
- Work with local agencies to provide joint strategic leadership on MCA and DoLS in partnership with Local Authorities, provider clinical governance teams and safeguarding leads, CQC, and where applicable, the police.
- Ensure that provider contracts specify compliance with MCA and DoLS legislation and that commissioned services are supported and contracts monitored for compliance with MCA.
- Ensure that learning from cases where mental capacity has been an issue will be used to inform future commissioning and practice.
- Ensure that leads for safeguarding adults and mental capacity within the organisation have broad knowledge of healthcare for older people, people with dementia, people with learning disabilities, and people with mental health problems.
- Ensure that safeguarding and MCA leads work within the local health and social care economies to influence local thinking and practice around MCA.
- Ensure that best practice around mental capacity is promoted, implemented and monitored both within the organisation and within commissioned provider.
- Guidance in relation to how this can be achieved within the CCG and GP member practices can be obtained on the following link.

10.0 Duties and Responsibilities within the CCG

10.1 The Chair

The Chair has overall responsibility to ensure that safeguarding processes and systems that include MCA/DoLS are discharged safely within the CCG and across the health economy.
10.2 Managing Director

The Chief Officer of the Wandsworth and Merton CCG has overall responsibility for ensuring that duties as set out under the Mental Capacity Act and related DoLS are implemented within the CCG and providers across the local health economy through the CCG’s commissioning arrangements.

10.3 Director for Quality and Governance

The Director for Quality and Development has the responsibility for assuring the Governing Body in any issues relating to the implementation of the MCA/DoLS requirements.

10.4 Duties of Mental Capacity Act Lead CCG and GP Member Practices (combined role with Adult Safeguarding)

The CCGs and GP member practices are required to have an MCA Lead who has responsibilities for providing support and guidance to staff and clinicians in any individual cases that may arise. The role also includes providing supervision for staff in situation where there are complex issues in relation to MCA.

Within the CCG, the role for MCA lead is undertaken by the Adult Safeguarding Lead and GP member practices can also consider the same. They will act as the lead for ensuring the appropriate implementation of the processes and statutory systems in relation to the MCA and DoLS in the following:

- Referrals are recorded and effectively screened. The required assessments are conducted.
- Appointments of Independent Mental Capacity Advocates and the relevant person’s representative.
- Ensuring that reviews and re-assessments are conducted.
- Effective operational links to ensure consistent and appropriate decisions are made between statutory and other agencies in the operation of the Deprivation of Liberty Safeguards.
- Involved in the promotion of best practice in Safeguarding Adults in the area of MCA/DoLS.
- Provide a safeguarding service to adults to include carrying out best interests assessments under DoLS.
- Chair appropriate review meetings and represent NHS Wandsworth and Merton CCG on any appropriate adult safeguarding meetings.
- Examine systems and processes relating to commissioning to ensure that any services commissioned are compliant with the MCA.
- The CCG MCA lead will provides practical advice and support to practitioners, GP practices and members of the public on safeguarding adult’s matters including the MCA/DoLS.

This will be achieved by undertaking auditing and also reporting through the governance structures and ensuring that staff identified within the CCG and providers have the relevant training in the MCA/DoLS. [http://www.scie.org.uk/mca-directory/mca-tailored-foryou/health/pan-london-commissioner-toolkit/files/mca-toolkit-guide.pdf]
10.5 All Staff

All CCG and GP member practices staff have the responsibility to ensure that MCA and DoLS are embedded within the organisation through any commissioning process/contracts. The CCG Adult Safeguarding Lead will identify the relevant training that relevant CCG staff are required to have. Whilst GP member practices safeguarding leads will support their staff in this to ensure that the organisation remains compliant with the requirements for implementing MCA/DoLS.

11.0 Commissioning arrangements

The CCG had responsibilities in ensuring that providers were services are commissioned have effective MCA systems and arrangements in place before accepting any services commissioned as part of the tendering and contracting processes. The commissioning team will ensure that the Safeguarding/MCA Lead in part of this process by requesting that they review any policies and procedures in relation to MCA/DoLS and that these are updated and reflect best practice.

NHS Wandsworth and Merton CCG has a responsibility to safeguard and promote the welfare of adults at risk through commissioning arrangements it also has responsibilities within its own activities, systems and processes.

12.0 Monitoring assurance and compliance

12.1 CCG responsibilities

Wandsworth and Merton CCG will require assurance from providers to ensure that the Act is embedded within process and systems to protect people who may lack capacity. This will be achieved in the following manner:

• the Act is given priority within the CCG and recognised as part of the commissioning process.
• provide guidance on what is required and needs to be achieved as an essential component of the tendering and contract awarding process.
• provide ongoing monitoring systems and processes that will demonstrate compliance which will be part of the performance and quality monitoring processes.

The CCG will also be required as part of the assurance process with NHS England to have systems and process that reflect that the MCA is embedded within the organisation to be able to demonstrate compliance.

12.2 CCG Provider responsibilities

Provider organisations are responsible for: ensuring compliance with MCA legislation (including DoLS) within and across their organisation.

Wandsworth and Merton CCG will need to be assured that any services they are commissioning, which will be used by the local populations is being delivered within the context of the person’s rights and that dignity and respect are central to that commissioning process. Therefore, systems and processes will need to reflect that people who may lack capacity are supported to make decisions that are in their best interest.
Any evidence of a failure to provide care within the MCA framework will be deemed unlawful. Although the provider organisation have overall responsibilities to ensure that the MCA is clearly embedded within the organisation and they are acting within the constraint of the law, the CCG equally will be liable.

The CCG will also be required to demonstrate as part of the Safeguarding Adult Board how they are implementing and monitoring the MCA within the organisation and that of providers.

Providers must be able to ensure that there is clarity as to who holds corporate responsibility for MCA and DoLS functions within the organisation, and that appropriate governance and safeguarding systems are in place to deliver best practice.

They must be in a position to provide assurance to the CCG that responsibilities with respect to MCA are being safely discharged.

The CCG will oversee provider responsibilities by ensuring that the following are implemented to demonstrate compliance with the MCA. These include:

- Relevant copies of service providers’ MCA policies.
- Evidence of an MCA Lead in each provider hospital.
- Evidence of MCA-compliant capacity assessments which demonstrates best interest decision-making relevant documentation and procedures.
- Evidence that demonstrates that the rights of patients are being advocated at all times within the context of the Act and that the organisation is complaint with this. This should include care planning policies and relevant training for all staff involved in this process.
- Evidence which demonstrates that the MCA is embedded within the hospital’s systems and processes which incorporates service users’ experience and advocates the maintenance of quality of their care and treatment.
- A policy that demonstrates that any research undertaken that involves patients recognises the ethical challenges involved and that the rights of any patients that participates in any research and lacks capacity are protected.

13.0 Mental Capacity within GP member practices

GP members practices should have systems in place that reflect that when practitioners are making decisions regarding people who may lack capacity should then consider the following key issues:

- Ensure that the GP or practitioners have provided the person with all the information they will require to make the decision.
- That all the alternatives available have been given to the person.
- That the communication needs of the person have been established.
- That methods have been considered to ensure that the person is able to maximise their abilities include verbal and nonverbal strategies.
- Ensure that an interpreter or any specialist resources required to aid the person in maximising their communication abilities are made available.
- Ensure that there is specialist adaptable equipment or easy to read literature available and that these can be easily accessible.
- Ensure that the time of day has been considered as the person’s abilities may vary.
- That the place to undertake the assessment has been considered, where the person may feel more comfortable.
• That an advocate has been identified and that the person has been asked and involved in identifying someone to assist in the process.

Every effort should be made to ensure that the person understands the information that have been given about the decision that needs to be made in the most helpful approach that maximises the person’s ability to engage. The process should not be hurried, unless this is in an emergency.

The information required includes:

• The nature of the decision.
• The rationale why the decision is required.
• Weighing out the alternative decisions that can be made and the impact this will have on the person.
• What could happen if this decision is not made?

GPs and other practice practitioners should recognise that mental capacity is time and decision specific. E.g. a person may be able to make a decision regarding whether they need to have a blood pressure done, however, may not necessarily understand the significance of refusing a referral to tissue viability as a result of developing a pressure ulcer that requires specialist wound care.

14.0 Undertaking a capacity assessment – CCG staff and GP member practices

According to the MCA, the legal starting point is the presumption that the adult is deemed to have mental capacity. The practitioner will then need to gather evidence to establish that the person meets the criteria as outlined in the five principles before any decisions and action can be taken in the best interest of the person.

The practitioner who completes the assessment must be able to justify the decision that has been made and why they believe that this is in the person’s best interest. The assessment would need to be completed at the time when practitioners feel there is a concern and that the person is not able to make an informed decision. For example, when the person requires a blood pressure to be taken which is non-invasive and for invasive procedures such as taking the patient’s blood test or treating a complex wound.

Practitioners will need to ensure that they appropriately assess the capacity and provide evidence for the decisions made when they feel that there is doubt regarding the person’s capacity.

14.1 Decisions in practice that are significant or complex

For decisions that require more invasive treatment, which may have a risk of adverse side effects, a more formal process is required, which requires practitioners to utilise forms that demonstrate that decisions has been made to reflect the complexity of the treatment or procedure.

14.2 Person responsible for undertaking a mental capacity assessment

The practitioner who is required to make a decision about the person should be directly involved in working with them at the time the decision needs to be made. Therefore,
different people may be involved in assessing the person’s ability to make a decision at different times. For more formal and complex assessments, a psychiatrist, psychologist, speech and language, occupational therapist or social worker may be used. The final decision should be made by the practitioner who is intending on making that decision to undertake treatment on behalf of the person who may lack capacity, and not necessary the practitioner who had been asked to advise.

14.3 Person responsible for making a decision

Under the MCA, the term decision maker is used to refer to practitioners who may be required to make decisions or act on behalf of the person. The decision maker identifies what is in the person who may lack capacity’s best interest. If the decision relates to the social care needs of the person, then a social worker will be the best person the assess these needs, whilst a decision relating to treatment of the person or procedure may best be made by a nurse or doctor delivering the care at that time. Other examples include a person’s ability to consent to hospital admission being made by a GP or paramedic. If a person has a Lasting Power of Attorney, or a deputy has been appointed under a court order, then the attorney or deputy will be the decision maker.

15.0 Independent Mental Capacity Advocate (IMCA)

This is an advocacy role that involves supporting the person in situations where there is no one who can be consulted. The person is not considered a decision-maker, however, the person who is the decision maker can take the information provided by the IMCA into account when making decision about the person.

Organisations will need to demonstrate that they have systems and processes to ensure that the person is provided with the services of an IMCA and this includes GP practices. Staff should have the awareness of how the advocacy service is implemented and when to ensure that people who may lack capacity are supported.

15.1 The role of the IMCA will include:

- Situations where the decision is about serious medical treatment;
- Where the person is to move into long term care that may last more than 28 days in hospital or 8 weeks in a care home.
- In care reviews where there is no one else to support the person.
- In safeguarding concerns irrespective of whether the person has family or friends involved in the care. The provision of an advocate is a requirement under the Care Act in safeguarding matters.

15.2 The duties of the IMCA will include:

- Establishing any alternatives of action.
- Supporting the person to gain any further information required regarding their medical treatment or expert opinions where required.
- Assisting in preparing any formal report that are required.
- They also have the ability to challenge the decision that may have been made by the decision maker.
- Support the person who lacks capacity to express their views, beliefs, preferences and to ensure that they are represented.
• Support the person who lacks capacity and represent their views and interests to the decision-maker.

16.0 Establishing mental capacity using the two stage test

According to the MCA 2005 "A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help him to do so without success." The person’s mental capacity may fluctuate; therefore, it is essential to complete the assessment at a time that maximises the person’s abilities to make the decision and factors that may influence the person’s ability and needs to be considered. Practitioners should be mindful that the person’s mental capacity may recover based on an acute illness that may be evident; therefore, a follow up assessment will need to be considered.

The MCA 2005 outlines the following two stage process:

16.1 Stage 1 – This stage considers whether the person has “an impairment or disturbance of the functioning of the mind or brain sufficient that the person lacks capacity to make that particular decision”?

Examples where there may be an impairment or disturbance of the functioning of the mind or brain:
• Dementia
• Learning Disability
• Depression
• Head injury
• Effects of alcohol or drugs

16.2 Stage 2 – Therefore to enable the practitioner to address the question outlined in Stage 1, there are factors that need to be considered, which will include: Has the patient demonstrated that they are able to:

• Communicate their decision using their preferred method of communication.
• Understand the information that has been conveyed to them and is relevant to the decision. Why the treatment or procedure important and relevant? Why is it being suggested? The practitioner should aim to provide this information in a clear, concise manner avoiding the use of complex jargon. The person should be able to understand the key points being conveyed.
• Retain the information and to process this to make an informed decision.
• Balance or weigh the information and understand the risk, benefits and any alternatives provided or suggested. If the person demonstrates that they have achieved the above, then they will be deemed to have capacity to make that decision. The nature and quality of the decision made is not the issue here, just because a person makes an unwise decision, does not demonstrate a lack of capacity. However, if the person fails on any of the key aspects above, they will be deemed to lack capacity on that specific decision. In this case, the practitioner will need to consider a best interest decision.

17.0 When Deprivation of Liberty Safeguards/Court of Protection are required

☐ If a practitioner believes that a person lacks capacity and requires treatment that is deemed to be in their best interest, then a DoLS/Court of Protection may be
required. However, they should have the documentary evidence to justify this decision. They should also be able to demonstrate how they arrived at that decision, the balance of probabilities that the person lacks the capacity to make that particular decision, at the time it needed to be made. The decision will need to reflect the five principales as outlined in the MCA.

17.1 Determining capacity when a person is unable to cannot communicate

- There are circumstances where the person may not be able to communicate at all, for example, the person may be unconscious, cannot speak or be able to move as a result of an illness or disorder. The Act advocates that the person should be treated as if they are unable to make a decision. However, this needs to be clearly highlighted and not confused with situations, where a person is not able to communicate because the practitioner has to not provide the person with the opportunity to maximise their communication abilities or use their preferred methods of communication.
- The 2014 ‘Acid Test’ from the Supreme Court Judgement clearly outlines that if a person does not object to leaving or to receiving treatment and care, this does not necessarily mean they are compliant. Therefore, they will need to be assessed within the context of a DoLS/Court of Protection.

17.2 Determining best Interest – DoLS authorisation and Court of Protection

A DoLS authorisation or Court of Protection will be deemed by the practitioner to be in their best interest. This will include evidence that all other least restrictive options were considered in the first instance, and that risks have been established, a balance between the needs and rights of the person and the restrictive intervention explored. Evidence to substantiate that the person will come to significant harm if the restrictions are not implemented will also be clearly evidenced following the assessment. However, prior to this, practitioners will still need to consider the following:

- **Regaining capacity** – delaying the decision may be required if there is evidence that the person may retain capacity or to provide support for the person to enable them to make the decision themselves
- **Encouraging participation** – the process should allow the person to participate in the decisions and to ensure that they are allowed time and to seek the support of an advocate or relative.
- **The person’s feelings and wishes** – the needs, wishes, preferences of the person must be considered at all times and ways identified to support them in this. This should also include issues around Advance Directives and Lasting Power of Attorney.
- **The views of other people** – the practitioner undertaking the assessment should also consider the views of people who know the person well and can be consulted on any issues that involve the person’s welfare. This also includes other practitioners who may be involved in caring for the person.
- **Do not make assumptions** – the practitioner making the decision should never make any assumptions regarding the person based on their illness, condition, age or appearance or behaviour.

Once the above have been considered, then the process of applying for a DoLS authorisation or Court of Protection will be initiated to protect the person. This process is explored further in the appendix.
Process for CCG Health Funded Patients in Supported Living/Domiciliary Care Settings

• If the patient is CCG funded and they reside in their own home or supported living, the following will be required:
• An MCA assessment will need to be established first to determine capacity. This can be completed by the CHC team or patient’s GP.
• The least restrictive options will need to be considered first without compromising the person’s health and wellbeing.
• If there is evidence that the person cannot be supported using the most restrictive options, then a Best Interest meeting will need to be arranged between the CHC team, CCG Adult Safeguarding Lead, the patient, relatives and other relevant professionals to determine if the person fits the ‘Acid Test’ criteria.
• If the patient meets the ‘Acid Test’ criteria and is joint funded with the Local Authority, then the decision will need to include them and the cost of the Court of Protection jointly funded.
• If the patient is full NHS funded, then the cost of applying for the Court of Protection Order is the responsibilities of the CCG. The process will need to be coordinated by the CCG Adult Safeguarding Lead following discussion and the advice of the CCG Legal team. The CCG Adult Safeguarding Lead will work with the CHC team to ensure that the relevant safeguards are in place to protect the person.
• If a person who lives in their own home or in rented accommodation and receives care and support directly from, or organised by their Local Authority who are under “continuous supervision and control”, the Local Authority will take the responsibility to take the case to the Court of Protection rather than authorise the deprivation of liberty themselves.

18.0 Establishing mental capacity in emergencies situations

An urgent decision and action will be required in an emergency situation. It will, therefore, not be appropriate to delay treatment whilst attempting to establish the person’s capacity to make the decision or to consult with any key individuals who may be involved in their care, such as a deputy or attorneys in an attempt to try and communicate with the person. Despite this, practitioners should continue to communicate any care needs and treatment with the person to ensure they are kept informed of what is happening. Therefore, in these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions.

19.0 Training

The CCG and GP member practices are required to provide training to relevant staff within the organisation. The CCG is also required to monitor the training compliance of providers to ensure that key individuals are trained. The recommended training that will be required to demonstrate compliance will have evidence of:
• Details of service provider’s training, which includes induction, refresher training and a policy.
• Reports demonstrating staff induction, training and refresher training records and these should also include attendance records to the training.
• To demonstrate that MCA is included in job descriptions and any personal or annual appraisals reviews, of all staff who work directly with patients.
• Details of arrangements where training has been provided for staff to deal with restriction and restraint, along with any associated record keeping.
• The CCG can assure themselves that issues around inappropriate use of restraint are documented clearly and that if any restraint is used, this is proportionate.
• That the MCA-related case law is fully explained and staff have had the relevant training relating to the significance of this within the person’s care.
• The use of the Code of Practice for staff as guidance and to ensure that they are familiar with the key issues highlighted in the Code. The CCG will be able to monitor this through the Joint Health Adult Safeguarding Subgroup meeting and CQRM. [http://www.scie.org.uk/mca-directory/mca-tailored-for-you/health/panlondon-commissioner-toolkit/files/commissioner-mca-responsibilities-checklist.pdf](http://www.scie.org.uk/mca-directory/mca-tailored-for-you/health/panlondon-commissioner-toolkit/files/commissioner-mca-responsibilities-checklist.pdf)

20.0 Policy Review

This policy will be reviewed every 2 years, and in accordance with the following on an as and when required basis:

- Legislative changes
- Good practice guidance
- Case law
- Serious Incidents
- Safeguarding Adults Reviews, (where applicable)
- Changes to organisational infrastructure

21.0 Equality impact assessment

21.1 All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on equality. This obligation includes equality and human rights with regard to disability, age, race and ethnicity, religion/belief sex/gender, sexual orientation, gender reassignment, civil partnership and marriage and pregnancy and maternity.

21.2 There is strong evidence that promoting all aspects of equality and diversity is closely linked to reducing gaps in health inequalities. Throughout the development of this policy/procedure due regard has been to ensure that the issues relating to Mental Capacity and DoLS arrangements described within this document protect the nine characteristics enshrined in the Equality Act 2010.

21.3 The Mental Capacity and DoLS Policy and Procedures is expected to have a positive impact on equality. As a responsible commissioner Wandsworth and Merton CCG works closely with the London Borough of Wandsworth and Merton and provider health care organisations to ensure the health of adults is positively promoted.

21.4 It is acknowledged that promoting all aspects of equality and diversity is closely linked to reducing gaps in health inequalities, and therefore, this issue is a key consideration within this policy for wider CCG contracting activities.
Appendix 1 Process when contemplation of the use of the Court of Protection is required
CHC or other CCG staff (the applicant) liaises with the Manager and DSA at earliest point and submits a briefing email

Director of Quality & Governance and DSA to advise if care can proceed and/or notify further actions needed e.g. chapter 15 Code of Practice

Case can proceed

The applicant and/or DSA to liaise with CCG solicitor for initial advice and a cost estimate if appropriate

Director of Q&G to approve proposal

Approved

Process continues applicant to produce and share documents. DSA to be routinely briefed and involve Director of Q&G

Where increasing complexity is identified which will incur an additional cost further direct input from the Director of Q&G required.

Case cannot proceed

General statement, Inc. reasons for rejection, sent to applicant informing them of what further work is required to manage the issue

Applicant to review the case and instigate actions. Case can be resubmitted to process if issues change.

Not approved

Rationale not to proceed discussed by relevant team, DSA, Director of Q&G and decisions noted.

Process completed
Designated Doctor for Safeguarding, Designated Doctor LAC, Designated Nurses for Safeguarding Children & Designated Nurse for LAC

Named GP for safeguarding children, Designated Doctor for Child Death. These key practitioners for children services will be offered support if required when dealing with 16-17 years who also come under the Mental Capacity Act, but may require referral back to children services to be considered under Fraser Guidelines if the decision to be made is too complex for them to deal with.

Designated Safeguarding Adults/MCA/DoLs/PREVENT Lead
## FURTHER GUIDANCE

### Mental Capacity Act Code of Practice

|---------------------|--------------------------------------------------------------------------------------------------------|

### Deprivation of Liberty Safeguards Code of Practice


### Royal College GPs


### General Medical Council


### Social Care Institute for Excellence

Guidance for CCG Staff and GP Member Practices on Mental Capacity Assessment
Adult at Risk

Yes

Is there a concern over the adult’s mental capacity to make decisions about their safety?

If yes, person concerned about their welfare should carry out a mental capacity assessment of the adult

No

Adult lack capacity about their safety

Adult with mental capacity to protect themselves

Views and wishes of the Adult gathered and followed as much as possible

Adult supported to make decisions e.g. by giving information and options of safety

Views and wishes of the Adult’s friends and or family gathered and considered

Risks of safety identified

Support or services offered to mitigate the risks of safety

Least restrictive alternative (of the Adult’s human rights) intervention considered e.g. person attends day activity rather than respite in a care home

Independent Mental Capacity Advocate (IMCA)

Care Act Advocate/other appropriate advocate

Best interest Checklist followed and decision maker decided for the Adult

Adult decides for themselves/consents
Guide for CCG Staff and GP Member Practices on when to appoint an advocate

Does the Adult have substantial difficulty?

Yes

Understanding relevant information
Retaining information
Using/weighing information
Communicating their views

Yes

Is there an appropriate individual to support

Yes

No

Is the appropriate individual able to fulfil the responsibilities?

No

Appoint an Advocate

Advocacy not required

Reference: Adapted from London Multi Agency Adult Safeguarding Policy and Procedures 2016
When visiting a care home or domiciliary care setting, is there evidence of the following:

- Is there evidence of physical or chemical restraint being used because the person is restrictive to intervention in care?
- Is there any evidence that the person is being made to cooperate against their will?
- Is medication being used covertly without safeguarding systems in place?
- Does the patient or relative object to the care being delivered?
- Is restraint being used, when a person is refusing treatment?
- Is there evidence of the person being cared for in a wheelchair/chair with straps around them, in bed with bedrails, not allowed to move or go out, or other forms of furniture and objects e.g. tables/chairs/stair guards/locked doors, restricting movement to other sections of the care setting. If these are used, there needs to be further exploration by the practitioner as to whether there are clear systems in place that reflect MCA being completed and Best interest/DoLS authorisation/Court of Protection implemented? Also there should be evidence that the least restrictive options were considered first.
- Has the person or relative requested the person being discharged and the care establishment is refusing this request?
- Is there evidence that the person is being refused relatives and friends visiting?
- Is there evidence in the care plan that the least restrictive options have been used first?
- Is there evidence that the person is being refused access into the community without any clear guidance and systems in place to support this?

The issues above would indicate that a person is being deprived of their liberty as outlined in the 2014 Supreme Court Judgement – Acid Test

- Is the person being cared over aged 18 or over?
  - Yes
  - No

- Reapply deprivation of Liberty Acid Test and establish if the person is subject to continuous supervision and control as part of their best interest care plan

- Are least restrictive options available which will be identified as being in the person’s best interest?
  - Yes
  - No

  Take all necessary steps to ensure that person is supported using least restricted options
<table>
<thead>
<tr>
<th>Patient may be deprived of their liberty, therefore an authorisation is required.</th>
<th>Undertake a Mental health Assessment</th>
</tr>
</thead>
</table>

Remember it is still a deprivation even if the person is compliant with care and does not object

Restraint must be reasonable and proportionate and deemed to be in the person’s best interest
<table>
<thead>
<tr>
<th>Level</th>
<th>Who</th>
<th>Course outline</th>
<th>Resources to support learning</th>
</tr>
</thead>
</table>
| Mental Capacity and         | This is for anyone who may work or come into contact with people     | • **MCA**  
  Deprivation of        aged 16 and over                                                                                                                                  |  
  Safeguards                                      |  
  **Level 1 - Foundation** |  
  • Explore the 5 principals of the MCA and the significance of this for patients.  
  • Be able to describe what the term ‘lack of capacity means’ and the importance of establishing that decisions are specific.  
  • Be able to identify the steps to support in the patient in any decisions made that is regarded as being in their Best interest.  
  • Be able to define the role of the IMCA and when they are appointed.  
  • Know the provisions of the MCA 2005 and the implications of this within the context of people who may lack capacity.  
  • **DoLS**  
  • Be able to explain what the term ‘restraint’ mean and identify the different levels.  
  • Be able to explain the legal basis for a deprivation and when it can be authorised.  
  • Be able to describe their role in identifying and reporting where there is evidence of deprivation of liberty.                                                                                                                                                                                                 |  
  ELearning Work book                                                                                                                               |                                              |
| Mental Capacity Act and     | All staff who have direct and regular contact with people aged 16     | • **As in Level 1 MCA and DoLS in addition to the following:**  
  Deprivation of Liberty   and over                                                                                                                                       |  
  Safeguards                                      |  
  **Level 2 - Intermediate** |  
  • Explain the role of a decision maker and the process in the event that they are not the decision maker.  
  • Be able to describe undertaking a mental capacity using the 2 stage assessment process.  
  • Be able to explain how the decision maker can consider making decisions that are in the person’s best interest and this includes least restrictive options.  
  • Be able to demonstrate how recording of capacity assessment and best interest decisions are made.  
  • Explain the role of LPA, Deputies and IMCA.  
  • Explore key issues in relation to End of Life care planning and the decisions to be made around DNACPR.  
  • **DoLS**  
  • Explain DoLS within the capacity of the European Convention for Human Rights and the relevant Articles of 5 and 8.  
  • Explain the process of undertaking a deprivation of liberty safeguard process within a care home/hospital and domiciliary care setting to include the restrictions to be considered and how evidence of the least restrictive options can be generated and considered in the first instance.                                                                                                                                                                                                 |  
  Face to face via the LBN ELearning Briefings                                                                                                     |                                              |
Mental Capacity and Deprivation of Liberty Safeguards

<table>
<thead>
<tr>
<th>Level 3 - Expert</th>
<th>For senior members of staff who may have a lead role and responsibility for MCA/DoLS and also for continuing health care</th>
</tr>
</thead>
</table>

As Level 1 and 2 MCA/DoLS and in addition to the following:

- Demonstrate the ability to mentor and coach others in any issues relating to the MCA/DoLS practice and development.
- Know the requirements for having systems in place relating to MCA/DoLS and that includes policies and procedures.
- Know the process that is required to refer a person for Court of Protection and the legal implications around this.
- Demonstrate the ability to utilise Court of Protection documentation.
- Know how to interpret the implications of current case laws and court judgements in relation to DoLS and the implications for the decision making process within practice.

Face to Face Training Briefings