Morecambe Bay
Primary Care Collaborative

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Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Document Reference	POL019
Purpose	This policy is based on the principles of the Mental Capacity Act (MCA), a statutory framework for people who lack capacity to make decisions, or who have capacity and want to make preparations for a time when they may lack capacity in the future.
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1. INTRODUCTION

1.1 Summary

The MCA was introduced into England and Wales in April 2007. It sets out who can make decisions, in which situations, and how they should go about it. It applies to all those involved in providing health and social care and is supported by a Code of Practice 2007 which gives guidance on its implementation and has statutory force. This includes doctors, nurses, allied health professionals and care staff. The Code of Practice can be found here.

The starting point of the Act is it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The Act sets out how capacity should be assessed and procedures for making decisions on behalf of people who lack mental capacity. 'The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests'

The Act outlines:

- Who can make decisions for people who lack capacity
- In which situations this can be done
- How they should go about this.

1.2 Purpose

The aim of this policy is to ensure that throughout the work of MBPCC we will promote the welfare of adults in ensuring the principles of the MCA are embedded into practice. We aim to do this by ensuring that we comply with the MCA Code of Practice and upholding the rights of adults with care and support needs ensuring it is integral to all we do.

MPCC is committed to implementing this policy and the practices it sets out. The Provider will offer learning opportunities and make provision for appropriate MCA training to all staff and will also ensure the MCA Code of Practice is available to all staff. This policy will be made widely accessible to staff and reviewed on a regular basis.

The Lancashire Safeguarding Adults Board has a dedicated section on MCA where there is access to learning resources; this includes an E- book, media resource and other useful learning tools. The link can be found here.

This policy addresses the responsibilities of employees; it is the responsibility of the care provider manager and the MCA Lead to brief staff on their responsibilities under the policy.

1.3 Scope

This policy applies to all MBPCC employees and directors.

From time-to-time MBPCC may utilise the resources of sub-contractors to deliver contractual obligations. For avoidance of doubt, where a sub-contractor is providing care to patients, as laid out in the contracts between MBPCC and subcontractors, they are solely responsible for delivery of the

regulated activity they are providing and must ensure all their employees operate under their own policies which must meet the relevant CQC standards. MBPCC will seek assurance from all sub-contractors that suitable policies are in place and may at their discretion request copies of any relevant policies for review and for verification. In such cases this policy document does not apply.

1.4 Breaches of Policy

For employees, failure to adhere to the MCA Policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with the MBPCC may be terminated. For commissioned and/ or registered providers, failure to ensure adherence to the MCA Policy could lead to breach of contract and/or breach of CQC standards (Regulation 9 Person-centred care).

2. PROCEDURE

2.1 Principles

MBPCC recognise the responsibility to ensure adherence to the MCA and to support adults who are not able to make their own decisions, to support them to plan ahead, if they wish for a time when they may lose capacity. The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. The Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

Joint working and effective collaboration is essential to promote the rights and freedom of individuals. This is supported by:

- The commitment of all staff and clear lines of accountability, to comply with the principles of the MCA and the Code of Practice, which protects them from liability
- Practice developments that take account of the need for staff training and continuing professional development so that staff have an understanding of their roles and responsibilities and those of other professionals and organisations in relation to MCA
- Building confidence among staff regarding how and when to assess and individual's mental capacity, and how to make a best interests decision when necessary

The five statutory principles of the MCA

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

What is mental capacity?

Having mental capacity means that a person is able to make their own decisions by weighing up relevant information. All staff should always start from the assumption that the person has the capacity to make the decision in question (**principle 1**).

Staff must also be able to show that they have made every effort to encourage and support the person to make the decision themselves (**principle 2**).

Staff must also remember that if a person makes a decision which is considered eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (**principle 3**).

Under the MCA, staff are required to make an assessment of capacity before carrying out any care or treatment if they have reasonable belief someone lacks capacity – the more serious the decision, the more formal the assessment of capacity needs to be.

When should capacity be assessed?

Capacity is **decision and time specific**, assessing capacity refers to assessing a person's ability to make a particular decision at a particular moment in time, rather than being an overarching judgement about an individual's ability to make decisions in general. Staff cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.

The MCA 2005 defines lack of capacity as:

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.

The Act assumes that a person has capacity until it is proven otherwise.

Capacity should be assessed when a person's mental capacity to consent to their treatment or care is in doubt. Capacity may be called into question for a number of reasons including:

- An individual's behaviour or circumstances
    - Where concern about capacity has been raised by someone.
    - Where a person has been previously diagnosed with an impairment or disturbance that affects the way their mind or brain works
- A previous mental capacity assessment has shown lack of capacity to make a decision

Further information can be found in Appendix A in the checklist for practitioners applying

the MCA.

Consent and Capacity

You must have reasonable belief that the individual lacks mental capacity to have legal protection under the MCA 2005 for making decisions on a person's behalf. To have reasonable belief, you must take certain steps to establish that the person lacks mental capacity to make a decision or consent to an act at the time the decision or consent is needed.

You must establish and be able to show that the decision or act is in the person's best interests. A mental capacity assessment must be completed using the two and four stage tests outlined in the introduction and demonstrated in Appendix B.

A mental capacity assessment helps demonstrate that on a balance of probabilities it is more likely than not that the person lacks capacity. You should be able to show in your records why you have come to your conclusion that capacity is either present or lacking for the particular decision.

Not all decisions will need a formal mental capacity assessment and the outcome can be recorded within the service user records and care plan. Consent for the person's care plan will cover many day-to-day decisions, but there will be times when a formal mental capacity assessment should be undertaken. Formal mental capacity assessments to assess the mental capacity for an individual to make a particular decision at a particular time should be kept in the patient care records.

Examples of when to undertake a formal capacity assessment include, but are not exclusive to:

- Use of bed rails
- Use of restraint
- Any invasive procedures
- Covert medication
- Any procedures where the resident is handled for the provision of care and treatment
- Medical photography

If the decision to be made is complex or may have serious consequences or, if there is disagreement about a person's capacity, or a safeguarding issue, then there may be times when you need to involve other professionals and colleagues in carrying out a mental capacity assessment and/or best interests decision.

Occasionally an individual may object to having a mental capacity assessment. Where this happens it is good practice to explain what the mental capacity assessment is and how it will help to protect their rights. There should be no undue pressure for the person to have the assessment, as a person has the right to refuse.

If it is clear that the person lacks the mental capacity to consent to the assessment and there are concerns or risks about the person's care and treatment, then the assessment can usually go ahead as long the assessment is in the person's best interests.

The two-stage functional test to assess capacity

In order to decide whether an individual has the capacity to make a particular decision staff must answer two questions:

Stage 1. Is there an impairment of, or disturbance in the functioning of a person's mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol.

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The MCA states that a person is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision

- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or other professionals and identify when the person is at their best before undertaking the capacity assessment.

Variations in capacity

The MCA covers all types of decisions, big and small. This may be from the day-to-day, such as what to wear or eat, through to more serious or complex decisions, about, for example, where to live, whether to have surgery or how to manage finances or property.

The MCA applies to situations where someone is unable to make a particular decision at a particular time because of the way their mind or brain is affected. When suffering from depression, infection or suffering from delirium, an individual may be unable to make a decision, but when recovered they can.

People should receive support to help them make their own decisions, before it is concluded that they may lack capacity to consent to a particular decision. It is important to take all possible steps to help them reach a decision themselves.

2.2 Best interest's principle

It is important for the application of the MCA to have a fundamental understanding of the best interest's principle.

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests (**principle 4**). The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made. It is imperative that the staff member identifies and alerts the correct decision maker at the start of the process.

What is 'best interests'?

The MCA provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests and achieve least restrictive practice (**principle 5**).

Some of the factors to take into consideration are:

- Do not discriminate or make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect their behaviour
- Take into account all relevant circumstances
- If faced with a particularly difficult or contentious decision, it is recommended that practitioners adopt a 'balance sheet' approach, see Appendix D
- Will the person regain capacity? If so, can the decision wait
- Involve the individual as fully as possible
- Take into account the individual's past and present wishes and feelings, and any beliefs and values likely to have a bearing on the decision
- Consult as far and as widely as possible.

It is vital that staff record the best interest's decision. Not only is this good professional practice but given the evidence-based approach required by the MCA, you will have an objective record should the decision or decision-making processes later be challenged. A template can be found in Appendix 3.

Dealing with disputes and disagreements

There may be occasions when someone may challenge the results of an assessment of capacity. In this situation it is important to raise the matter with the person who carried out the capacity assessment. If the challenge comes from the person who is said to lack capacity, they should be referred to an advocate if they are un-befriended or may need support from family or friends.

If you believe the capacity test findings are not accurate, provide reasons why you believe the assessment not to be accurate along with objective evidence to support that belief.

If the dispute cannot be resolved a second opinion may be required from an independent professional or another expert in assessing capacity. If the disagreement can still not be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection. Seek advice in this instance from the Local authority or CCG MCA lead.

Commented [GC1]: Should this be LSCFT MCA lead now?

2.3 Important Aspects of the MCA

Lasting Power of Attorney (LPA)

There are 2 types of LPA:

- Health and personal welfare
- Property and financial affairs

A person can choose to make one type or both types. The MCA allows a person aged 18 and over (the donor), who has capacity to make this decision, to appoint attorneys to act on their behalf should they lose mental capacity in the future. The Property and Affairs LPA replaces the previous Enduring Power of Attorney (EPA).

Lasting power of attorney (LPA) is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. This gives them more control over what happens to them if they have an accident or an illness and can't make their own decisions if they 'lack' mental capacity.

A health and personal welfare LPA allows the attorney to make specific decisions when the person is no longer able to consent to treatment or care. The attorney is able to make decisions about day-to-day care, consenting or refusing medical treatments, moving accommodation, refusing life sustaining treatment, assessments for provision of community services, social activities and more.

A property and affairs LPA allows the attorney to make specified financial decisions when the person lacks capacity, but unlike a health and personal welfare LPA, a property and affairs LPA can be used even if the person has capacity (with permission).

All lasting power of attorneys should be checked either with the Office of the Public Guardian, or the attorney can be asked to provide a copy. This is to ensure that it has been registered and valid and to clarify what decisions the attorney is allowed to make under the terms of the LPA. For example, they may have been given authority to make choices about accommodation but not to refuse treatments.

A lasting power of attorney must be registered with the Office of the Public Guardian before it is valid and can only be used once the person who made it no longer has capacity. Records must reflect whether an LPA has been registered and what decisions are given to the attorney.

Court Appointed Deputies

The MCA (2005) provides for a system of court appointed deputies who are able to make decisions on welfare, healthcare, and financial matters as authorised by the Court of Protection. They are not able to refuse or consent to life sustaining treatment. A deputy will only be appointed if the person lacks capacity to make an LPA and it is thought necessary or beneficial to appoint an individual to make ongoing decisions on their behalf. A deputy may be appointed for personal welfare matters, or property and affairs, or both.

Court of Protection

The Court of Protection is a superior court of record, it is able to establish precedent, set examples for future cases and build up expertise in all issues related to lack of mental capacity. It has the same powers, rights, privileges and authority as the High Court. When reaching any decision, the court must apply all the statutory principles set out in section 1 of the Act. It must make a decision in the best interests of the person who lacks capacity to make the specific decision. There will usually be a fee for applications to the court.

Advance Decision to Refuse Treatment (ADRT)

The MCA (2005) creates ways for people 18 and over, to be able to make a decision in advance to refuse treatment if they should lack capacity in the future. An advance decision to refuse treatment that is not life sustaining does not need to be in writing, but the person must ensure the relevant professionals know what treatment is being refused.

For an advance decision to refuse treatment to be valid, health professionals must try to establish if:

- The person has done anything since making the advance decision that would clearly suggest that they no longer agree with the advance decision
- The person has withdrawn the advance decision
- Power has been given to an attorney to make the same treatment decision as covered in the advance decision
- The person would have changed their mind if they had known more about the current circumstances.

For an advance decision to refuse life sustaining treatment to apply, the person must no longer have capacity to make the decision for themselves. The advance decision must be in writing, stating exactly what treatment is to be refused and set out the circumstances when the refusal should apply, even if there is a risk to life. The advance decision must be signed by the person refusing the treatment with the signature witnessed and signed in the presence of the patient.

The Court of Protection may be asked to decide whether the advance decision exists, is valid or applicable to the current situation, if the advance decision is called into question. While a decision is being made by the court, life sustaining treatment or treatment necessary to prevent a patient's deterioration may still be provided. Advance decisions can only be made to refuse treatment; not to demand a treatment choice.

Independent Mental Capacity Advocate (IMCA)

The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.

IMCAs must be independent and then consulted, for people lacking capacity that have no-one else to support them whenever:

- 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
- The person will stay in hospital longer than 28 days, or they will stay in the care home for more than eight weeks

The Act states that an IMCA may be instructed to support someone who lacks capacity to make decisions concerning care reviews, where no-one else is available to be consulted and adult protection cases, whether or not family, friends or others are involved. The policy in Lancashire is that an IMCA should be instructed under these circumstances.

2.4 Mental capacity and young people

Many aspects of the Mental Capacity Act apply to people aged 16 and over who may lack capacity to make a specific decision. However, the legislative framework for those cared for under The Children's Act 1989 will continue to apply until they are discharged from such care proceedings.

There are two elements of the Act than can be applied to young people under the age of 16: Decisions about property or finance made by the Court of Protection, and offences of ill treatment and wilful neglect.

For young people aged 16 and 17, the capacity assessment or Gillick competency test must be used to determine whether the health or social care decision should be subject to the processes and provisions outlined within the Act. Depending upon the decision staff may then use the Children Act 1989 or the Mental Capacity Act to proceed with making or proposing a decision for the young person lacking capacity. An adult with parental responsibility may consent to a proposed decision on behalf of a young person who lacks capacity or Gillick competency. However, due to the interface between the MCA, the Children Act, and the concept of Gillick competence for complex cases it may be necessary to seek guidance from the local identified Safeguarding MCA lead, and/ or legal advice.

Where staff can demonstrate that they have acted in accordance with the Mental Capacity Act their actions will be protected from liability whether or not a person with parental responsibility consents. A young person's views on whether their parents should be consulted during the best interest's process should be considered.

Where staff choose to proceed with consent from someone with parental responsibility, they must inform the parent that they are required to act in the young person's best interests as outlined within the Act.

For those services working with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families in becoming familiar with the powers and provisions within the Act is an essential part of transition work. Families may choose to approach

the Court to become Court Appointed Deputy for welfare decisions or property and finance decisions. Information should be provided to assist with such applications.

2.5 Restraint

The Act defines use of restraint as the use of force-or threaten to use force-to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.

The Act only provides protection from liability in using restraint under certain conditions:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood of serious harm
- Less restrictive options should always be considered before restraint
- The Act describes a proportionate response as one that means using the least intrusive type and minimum amount of restraint to achieve a specific outcome

The Act only gives limited liability for use of restraint. Actions may not be lawful where there is an inappropriate use of restraint or where a person who lacks mental capacity is deprived of their liberty without appropriate authorisation.

2.6 Deprivation of Liberty and The Supreme Court Judgement: P v Cheshire West 2014

The Act recognises that in some cases there is no other way to provide care and treatment other than by depriving a person of their liberty.

The Supreme Court Ruling introduced an acid test for determining whether an individual was being deprived of their liberty.

There are two key questions to consider regarding the 'acid test'

1. Is the person subject to continuous supervision and control?

2. Is the person free to leave?

The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave.

For a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave.

Following the ruling it is **NOT** relevant if the individual doesn't object or complies with the deprivation, the relative normality of the placement or the reason or purpose behind the placement is **NOT** relevant.

Significantly the judgement highlighted that deprivation of liberty occurs in a domestic or supported living arrangements as well as hospitals and care homes.

The Act provides a legal framework and two distinct routes for authorising deprivation of liberty: 1. The Deprivation of Liberty Safeguards (DoLS) for people in hospitals and care homes and 2. The Court of Protection for people living in all other community settings.

Deprivation of Liberty Safeguards (DoLS) 2009 – hospitals and care homes

DoLS were created to help protect vulnerable people who lack capacity to consent to care and treatment that might deprive them of their liberty, where this is in their best interests to protect them from harm. DoLS are an extra protection for vulnerable people to ensure that deprivation is only used when necessary and that any deprivations are lawful and, in the person's, best interest.

DoLS only relate to people aged 18 or over, who are not detained under the Mental Health Act 1983, and who are accommodated in a registered hospital or care home.

A deprivation of liberty must be in a person's best interests, which means that as part of the process those with an interest in the person's health and welfare should be consulted and given an opportunity to give their views. Where the person has no interested party outside of those providing care or treatment then the supervisory body will instruct an IMCA.

A person may only be deprived of their liberty if:

- it is in their best interests to protect them from harm
- It is appropriate and proportionate to the threat of harm
- It is the least restrictive option

There have been a number of Supreme Court Rulings that have affected the implementation of the Act. This policy reflects legal developments up to the date of publication. The DoLS Code of Practice 2009 defines the difference between a deprivation of, and restriction upon, liberty, as one of degree or intensity.

A person's treatment and care may move along the scale of restriction of liberty and deprivation over time and circumstances. It is therefore, important for DoLS to be reviewed regularly and any actions documented to demonstrate that care is least restrictive and recorded in the individuals care plan. Case law has helped determine factors that might indicate a person is subject to deprivation rather than restriction or restraint

The managing authority (care home/ hospital) has the responsibility to make the application for authorisation from the supervisory body. A supervisory body is responsible for receiving the requests for authorisation, commissioning the assessments and where agreed authorising the request for deprivation. For care homes and hospitals the supervisory body is the local authority where ordinary residence is established or where a person is of no fixed abode, the borough of the care home.

Common Indicators that a person is being deprived of their liberty

- a decision has been made by the care home or hospital that the person will not be released into the care of others, or permitted to live elsewhere unless the care home or hospital considers it appropriate
- the person is under continuous supervision and control
- the person is being restrained
- the care home have refused a request by carers to discharge a person into their care
- the person is not free to leave the care setting without permission
- the person does not have access to friends, family or social contacts
- sedation has been used to admit the person to the care setting that has been resisted

Types of DoLS authorisations

There are two types of authorisation, standard and urgent. A standard authorisation is used where it is anticipated that a deprivation is going to occur within 28 days, and so should be done in advance of any deprivation. It is important to remember that an authorisation only permits a deprivation; it does not mean that a person MUST be deprived of their liberty.

An urgent authorisation should be made when a person is already deprived of their liberty in their own best interests. At the same time, an application should be made for a standard authorisation. The urgent authorisation covers the period before a standard authorisation can be processed. A standard authorisation should then be processed by the Supervisory Body within 7 days of the urgent authorisation. Urgent authorisations can only be given for 7 days; but may be extended by the supervisory body for a further 7 days at the request of the managing authority in exceptional circumstances.

Under the terms of the Act, assessments must be commissioned by the supervisory body within 21 days of an application for a standard authorisation. Where there is already an urgent authorisation in place then the assessment needs to take place before the urgent authorisation expires. Since the introduction of the Cheshire West Judgement, it is recognised due to the lowered threshold of the DoLS criteria that the supervisory body has an increased backlog of DoLS awaiting authorisation.

Once all the assessments have been completed and submitted, the supervisory body will make a decision whether to authorise the deprivation or not. Where a deprivation is authorised it will be time limited in line with the recommendations of the assessor (but for no longer than 12 months).

If, during the period of this authorisation, it appears that one or more of the qualifying requirements is no longer met or that it would be appropriate to amend or delete an existing condition, then the managing authority should request a review of the standard authorisation.

The managing authority must apply to the supervisory body for a further standard authorisation before the expiry date, if they think the person will continue to be deprived of their liberty, or earlier if it appears one or more of the qualifying requirements is no longer met. There is no statutory time limit on how far in advance of the expiry of one authorisation the managing authority can apply. If the person under the DoLS moves to another hospital or care home then a new application for DoLS will need to be made. This should happen in advance of the move.

All authorisations should be kept in the person's care records, it is important that friends, family and carers are kept up to date. The managing authority must take all practical steps to ensure that the relevant person understands the effect of the authorisation and their rights around it, including their right to challenge the authorisation via the Court of Protection, their right to an IMCA and their right to a review.

DoLS should be kept under review. Where capacity fluctuates it is important to recognise where capacity has returned in the longer term. Where capacity returns for short periods of time the authorisation should remain in place

Relevant person's representative

The relevant person's representative RPR is appointed by the supervisory body for each person who has a standard DoLS authorisation. The role of this person is to maintain contact with the person subject to DoLS and represent and support them in any matters relating to the deprivation. It is important that the RPR is informed of:

- The effect of the authorisation
- Their right to request a review
- Their right to make a complaint and the procedure for doing so
- Their right to apply to the Court of Protection and their right to request an IMCA.

Deprivation of Liberty Court of Protection applications – Community settings other than hospitals and care homes

Where there are deprivations of liberty in a domiciliary setting the commissioner of the care package is responsible for ensuring that the case is referred to the Court of Protection (COP). The commissioner is usually the Local Authority (LA) or the Clinical Commissioning Group (CCG).

Providers are responsible for identifying anyone in their care who they believe meets the Cheshire West Acid Test for deprivation of liberty, and for referring them to the LA or CCG to request a COP application.

The provider should ensure that they have assessed the person's capacity to consent to all the restrictions in place, and that these are in the person's best interests to protect them from harm. They should reduce or end any restrictions that are not in best interests.

If the LA or Commissioning Support Unit (CSU) is acting on behalf of the CCG to progress with the COP application, the provider will be required to support the process by providing all relevant documentation, including an up to date and signed copy of the care plan. If the judge approves the application and care plan, a time limited Order will be issued authorising the deprivation of liberty (but for no longer than 12 months). The COP will appoint a representative (usually a family member) to oversee the care plan and to visit the person regularly. The COP must review the Order via a new application submitted 4 weeks before the end date, or sooner if the restrictions increase. A COP Order is a confidential document which can only be shared with those named on the Order itself.

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Incapacitated 16/17 years olds in accommodation

Incapacitated 16/17 years old young people who are deprived of their liberty according to the acid test, do not necessarily require either a DOLS or COP Order to authorise the arrangements. A Court of Appeal judgment 1 November 2017 changed the law on the deprivation of liberty (DoL) for 16- and 17-year-olds. The current legal position outlined in the Court of Appeal judgment (D (A Child) [2017] EWCA Civ 1695), held that where a child of 16-17 years cannot make the relevant decisions for themselves, the consent of someone with parental responsibility (but not the LA for a child under a Care Order) is sufficient to mean there is no DoL that needs authorisation, even if the other elements (the acid test and immutability to the state) are met; a summary of the case law can be found here. A further appeal to the Supreme Court is anticipated.

2.7 Further Information

DoLS templates and further information can be found here.

For advice and support please use the contact numbers below

Useful Contact Numbers	
Lancashire County Council DoLS team between 9am - 5pm	01772 535444

Cumbria DOLs team	01228 226170/226171
Out of hours	0300 123 6720
Lancashire County Council COP Coordinator	01772 536011

3. REFERENCES

Mental Capacity Act – 2005 - https://www.legislation.gov.uk/ukpga/2005/9/contents

P V Cheshire West – 2014 - https://www.supremecourt.uk/cases/docs/uksc-2012-0068-judgment.pdf

4. DEFINITIONS/GLOSSARY OF TERMS

Abbreviation or Term	Definition
MBPCC	Morecambe Bay Primary Care Collaborative
MCA	Mental Capacity Act
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
LPA	Lasting Power of Attorney
EPA	Enduring Power of Attorney
ADRT	Advance decision to refuse treatment
IMCA	Independent mental capacity advocate
DoLS	Deprivation of liberty safeguards
RPR	Relevant persons representative
LA	Local Authority
COP	Court of Protection
CSU	Commissioning Support Unit
CAD	Court Appointed Deputy

5. CONSULTATION WITH STAFF, PRACTICES AND PATIENTS

Name	Job Title	Date Consulted
Emma O'Kane	Safeguarding and Quality Practitioner	27/08/2020

6. DISSEMINATION/TRAINING PLAN

Action by	Action Required	Implementation Date
Jo Knight/Boyana Konar	Upload policy to MBPCC website	Following approval of V0.1 end Sept 2020
Jo Knight	Host current copy on Federation G Drive (supporting induction process), updating Policy tracker	Following approval of V0.1 end Sept 2020
Andrew Giles	Ensure all employees are aware of the policy and are asked to read and understand it	MBPCC Board Meeting 22/09/20
Liz Stedman	Upload to TeamNet	Jan 2021

7. AMENDMENT HISTORY

Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V0.1	20/09/2020	All	New policy - adoption of the CCG model policy	
V1.0	22/09/2020	N/A	MBPCC Board Approval	22/09/2022
V1.1	19/01/2021	Page 17	Additional Definitions/Glossary of Terms added	
V1.2	01/03/2023	Various	Typographic/grammatical amends only	
V2.0	01/04/2023		MBPCC Board Approval	01/04/2026

8. APPENDICES

Appendix 1: Checklist for Practitioners Applying the Mental Capacity Act

Checklist for Practitioners applying the Mental Capacity Act
5 Principles: Apply them in practice 1. Assume the person has capacity unless proven otherwise. 2. Enable capacity by assisting the person when making a decision (use visual aids/ written words/ interpreters etc. as appropriate). 3. If a person with capacity makes an unwise or eccentric decision this must be respected. 4. If a person lacks capacity treatment decisions must be made in the person's best interests (follow the statutory checklist) 5. The treatment given should be the least restrictive option to the person's rights and freedoms. Ref Code of Practice Chapter 2
Enabling Capacity: Have you, • Been clear about what decision needs to be made, define it clearly and concisely (this helps in other aspects of the Act) • Made every effort to enable the person to make the decision themselves, by being flexible and person-centred. • Provided information about the decision in a format that is likely to be understood including information relating to any alternative options. • Used a method of communication/language that the person is most likely to understand. • Made the person feel at ease and given consideration to what is likely to be the most conducive time and location for them to make the decision. • Considered if others can help the person understand information or make a choice. Ref Code of Practice Chapter 3
Assessing capacity: Does the person have an impairment or disturbance in the functioning of the mind or brain? (temporary or permanent) If yes practitioners must complete the 4 part functional test. Can the person…. 1. Understand the information relevant to the decision? 2. Retain the information long enough to make a decision? 3. Weigh up the consequences of making the decision? 4. Communicate their decision by any means? If the person fails to demonstrate ability in any of the four areas they would be deemed as lacking capacity to consent to or refuse that specific decision. Ref Code of Practice Chapter 4
Decision Maker: Have you, • Identified the decision maker • Identified if the person has a registered Lasting Power of Attorney (LPA) or a court appointed deputy (CAD) for personal welfare who can consent or refuse treatment. • Considered if decision can be delayed till the person regains capacity Ref Code of Practice Chapter 5; 7 & 8
IMCA: Does the person require an Independent Mental Capacity Advocate Ref Code of Practice Chapter 10

Deciding Best Interests: have you • Encouraged participation • Not discriminated or been driven by a desire to bring about death • Considered person's views and wishes • Promoted the person's rights • Identified if the person has an Advance Decision to Refuse Treatment (ADRT) that is valid and applicable. • Identified and spoken with family friends or others to be consulted • Considered all relevant factors • Reviewed the risks and benefits of the proposed procedure and its alternatives including not providing treatment. (options appraisal) • Reviewed and weighted all of the evidence considering medical social welfare emotional and ethical aspects. • Arrived at a decision • Communicated your decision and rationale • Put in place steps to implement the decision that is least restrictive Ref Code of Practice Chapter 5
Restraint: Restraint is use force – or threaten to use force – to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. Does what you are proposing fall within the definition of restraint? Is the restraint necessary to prevent harm? Is the level of restraint proportionate to the likelihood and severity of harm You cannot deprive of liberty without lawful authorisation Ref Code of Practice Chapter 6
Protection From Liability: Follow the Act; document it and you will receive protection from liability Ref Code of Practice Chapter 6

Appendix 2: Capacity Assessment Form

Patient Name			
NHS Number / Date of Birth			
Details of Person(s) Assessing Capacity:	**Name:**		
	Designation:		
	Contact number:		
Details of others consulted in capacity assessment process:			
Name	**Designation / relationship to person**	**Contact Details**	
Q1: How will the decision be made: Note how the decision is phrased is important in maintaining a focus on the decision to be made and the extent of the boundaries of the assessment of capacity.			
Q2: What is the nature of the impairment? Diagnostic Test: Detail the nature of the impairment of, or disturbance in, the functioning of the person's mind or brain? **If none can be detailed – the person has capacity. Discontinue the assessment.** E.g. Dementia, brain injury, forms of mental illness, significant learning disability, delirium, stroke, head injury, confusion, drowsiness or loss of consciousness, alcohol or drug intoxication.			
Q3: Functional Test: Please complete four part test, describing the practical and appropriate supports provided. Before embarking on the assessment it is useful to note the key factors for each section that the person would need to demonstrate in the assessment thereby creating a person specific benchmark against which to measure capacity.			
Q3.1. Does the person understand the information relevant to the decision to be made?		**YES**	
		NO	
Q3.2 Is the person able to retain the information / explanation long enough to make the decision?		**YES**	
		NO	
Q3.3 Is the patient able to weigh up the information in the decision making process?		**YES**	
		NO	
Q3.4 Is the person able to communicate the decision by using any means?		**YES**	
		NO	
If you assessed the person as **not being able to demonstrate ability in any one of the four areas** above the person would be deemed as lacking capacity to consent to or refuse the particular decision / treatment in question.			
Q4: What is the outcome of the assessment: Does the impairment or disturbance mean that the person is unable to make the specific decision detailed above at the time of this assessment?			

	YES	Detail the reason for your decision:
	NO	

Q5: If Yes to Q4 'person is unable to make the specific decision' Is there an Advance Decision to Refuse Treatment; Registered Lasting Power of Attorney or Court Appointed Deputy for welfare that has powers to make the decision?		**YES**
		NO
Q6: If Yes to Q5 the decision must be respected. **If No:** Is it likely that the person will regain capacity in the future?		**YES**
		NO
Q7: If Yes to Q6: Can the decision be postponed?		**YES**
		NO
Q8: If No to Q7: detail reasons why the decision cannot be postponed.		
Q9: Based on the information above the person lacks capacity and a decision will be required in best interest?		**YES**
		NO
Q10: If appropriate to the decision, have you referred the person to the Independent Mental Capacity Advocate (IMCA) service?		**YES**
		NO
Q10.1: Please give details of the date referral made, rational for deciding IMCA is required and details of information sent to IMCA service.		

I have provided all practical / appropriate support in assessing capacity, complying with the Mental Capacity Act 2005.

Appendix 3: Capacity Checklist

- **What is the decision to be made?** Think carefully of how the decision should be worded.
- **Do you have concerns that the person may not be able to make the decision for themselves?** Be clear that the concerns relate to the decision to be made, and not based on previous concerns related to other decisions.
- **If so, can the decision wait until the person can make the decision**? Is the person's condition likely to improve in time to make the decision such as recovery from physical illness?
- **What help may the person need to make the decision?** Do they need to have any experience of the decision to aid understanding or some practical input to give further information such as education or training?
- **How can this be provided and by whom?**
- **If the decision cannot be delayed who should assess capacity?** Anyone can assess capacity. More complex or life changing decisions may need professional input.
- **What practicable steps need to be taken before the capacity assessment commences?** Location of the assessment; timing; communication; health issues of the person; aids that may help the person.
- **What other considerations need to be taken into account?** The person's anxiety; do they want anyone else to be present; concerns about confidentiality; have they been told clearly what is happening.
- **What are the salient points of the decision that the person needs to know?** Do not expect the person to think about information that is not necessary to the decision. Relevant points only should be identified and these should be as straightforward as possible.
- **How will be information be presented to the person?** Think about how the person takes in information. Do you need to use pictures, photographs, video or audio recordings or any other methods that will make it easier for the person to take part in the decision making process.
- **What is the impairment in the functioning of the mind or brain, permanent or temporary?** This can be due to mental illness; dementia; significant learning disability; acquired brain injury; physical or medical conditions; delirium; concussion; symptoms of alcohol or drug use.

Once this is determined, follow the rest of the 2 stage test

Appendix 4: Best Interest Decision Form

Patient Name		
NHS Number / Date of Birth		
This form is only to be completed if the person lacks capacity for the specific decision to be made and full capacity assessment has been documented. The named decision maker should consider all relevant circumstances of which s/he is aware, and which it is reasonable to regard as relevant in making the decision on behalf of a person who lacks capacity. This should include medical, social, welfare, emotional and ethical matters. Under no circumstances must a best interest decision be made by the desire to bring about a person's death.		
Details of Decision Maker:	**Name:**	
	Designation:	
	Contact number:	
Details of others consulted in best interests process:		
Name	**Designation / relationship to person**	**Contact Details**
Decision to be made: how the decision is phrased here becomes important in helping to maintain a focus on the decision to be made and the extent of the boundaries of the best interests process (should be the same wording as decision on the capacity assessment).		
Consultation with Others: What are the views of family; friends; anyone engaged in caring for the person; anyone interested in the person's welfare; anyone named by the person to be consulted? Please give details of each person consulted and their views. Identify and maintain a copy of any additional information given:		
Assessment:		
Q1: Has the person been permitted and encouraged to participate as fully as possible in the decision making process? e.g. by simplifying information, using pictorial aids, having trusted family/friends involved to assist with communication. Please state what has been done to aid participation		

Q2: Have you considered the person's past and present wishes, feelings, beliefs and values that would have been likely to influence his/her decision if s/he had capacity? Include any relevant written statements made when competent or any religious, cultural, moral and political beliefs and values. Please state any that are relevant to the decision to be made:
Q3: Have you identified the relevant circumstances that s/he would take into account if they were making the decision themselves? Please detail which factors or circumstances would be important to the person e.g. a life-long gardener would want that to be taken into account when choosing accommodation:
Q4: What are the options for the decision to be made? List all options, including those which may not be available:
Q5: What are the identified risks of the options identified? Please list the risks identified for each available option:
Q6: What are the identified benefits of the options identified? Please list the benefits for each available option:

Q7: Is any form of restriction/restraint required in the identified options? *Restraint is the use of, or threat to use force to make a person do something they are resisting*.		**YES** **NO**
Q7.1: If yes: Give details of nature of restraint required in order to provide best interest treatment. The nature of the restraint must be a proportionate response to the likelihood of the person suffering harm if they were not to receive a best interest decision.		
Q8: Does the level of restriction /restraint required in order to provide best interest decision identify the need to consider Deprivation of Liberty safeguards?		**YES** **NO**
Q8.1: If yes; evidence care plans implemented to reduce the likelihood of Deprivation of Liberty Safeguards.		
Outcome of Best Interests Assessment: Please give details and reasoning for decision(s) made including why chosen option is in the best interests: **Note:** this section should demonstrate the weighing of information; reasons for discounting a particular person's view point or the manner in which weight has been applied to certain factors or certain people's views. It should demonstrate your analysis and findings as the named decision maker.		

Appendix 4: Balance Chart

Decision Maker:		
Attendees/ Consulted parties:		
Options available are:	**1.**	
	2.	

Benefits of	**Burdens of**
Benefits of	**Burdens of**
Weighting Tool Key Magnetic Significance *** Highly Significant ** Significant *	**Options agreed to be in best interests of NAME are:**