NHS
Calderdale
Clinical Commissioning Group

Mental Capacity Policy
with Deprivation of Liberties Safeguards

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2.0	30/01/17	Clare Robinson	FINAL	Minor amendments to reflect children and young people requirement updates. Change agreed with Chief Quality and Nursing Officer as non-material.	Staff Public

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1.0 INTRODUCTION

1.1 The Mental Capacity Act (MCA 2005) promotes the empowerment of individuals to make decisions for themselves as far as is possible and protects adults (16 years and above) who may lack capacity to make their own decisions. The Act came into force in 2007 to provide a framework for protecting people unable to make decisions for themselves and for those who wish to plan ahead for a time when they may lack capacity.

1.2 The MCA is built on five statutory principles that guide and inform decision-making when working with people who may lack capacity for making choices in some aspects of their life including their health care.

1.3 The underlying philosophy is that any decision made, or action taken must be made in the best interests of someone who lacks the capacity to make the decision or act for themselves. The Act requires an individual approach that prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person

1.4 The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity providing it can be demonstrated that:

- The principles of the MCA have been observed
- An assessment of capacity has been carried out and documented
- It is reasonably believed that the person lacks capacity in relation to the matter, and
- It is reasonably believed that it is in the best interests of the person for the action to be taken.

1.5 The Deprivation of Liberty Safeguards (DoLS 2009) apply to people aged 18 or over and their purpose is to prevent arbitrary decisions that deprive people who lack capacity of their liberty. People can be deprived of their liberty in hospitals, hospices, care homes, their own homes/shared lives and supported living accommodation.

1.6 The two codes of Practice for MCA and DoLS have statutory force meaning that there is a legal duty for certain people, including those providing health care, to have regard to the codes.

1.7 NHS commissioners require a good understanding of both MCA and DoLS so they can be assured that commissioned services are carrying out assessments of capacity appropriately and that decisions made on behalf of people who lack capacity are made in their best interests and no one is deprived of their liberty without the legal requirements. Staff working for the CCG in clinical roles needs to have a good understanding of MCA DoLS so that they can ensure their practice is lawful and safeguard service users/patients human rights

1.8 The MCA and DoLS are accompanied by statutory codes of practice:
www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

2.0 PURPOSE

2.1 This policy aims to ensure that no act or omission by Calderdale CCG as a commissioning organisation, or via the services it commissions, is in breach of the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards (2009) and to support staff in fulfilling their obligations.

2.2 In developing this policy Calderdale CCG (hereafter referred to as the CCG) recognises that the implementation of the Mental Capacity Act is a shared responsibility with the need for effective joint working between agencies and professionals.

2.3 The policy also aims to provide direction and guidance to all staff employed directly by the CCG who are involved in the assessment, care, treatment or support of people over 16 years of age who may lack the capacity to make some, or all, decisions for themselves.

3.0 SCOPE

3.1 This policy applies to all employees of the CCG, who have a responsibility to comply with the legal framework under the MCA and DoLS Acts.

3.2 The policy must be read in conjunction with the MCA 2005 itself and the MCA and DoLS Codes of Practice.

4.0 POLICY STATEMENT

4.1 The CCG requires its employees and those from whom it contracts services to be fully aware of their duties and responsibilities under the MCA 2005 and Deprivation of Liberties Safeguards, to have regard to the guidance in the Codes of Practice.

4.2 The CCG will ensure that all staff employed by them are aware of their responsibilities under the MCA and will ensure staff operate at all times in accordance with the MCA and the accompanying code of practice

5.0 ROLES AND RESPONSIBILITIES

5.1 The Governing Body

The CCG has delegated responsibility to the Governing Body for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents

5.2 The Chief Officer of the CCG

As Accountable Officer for the CCG, is responsible for ensuring that the organisational accountability for delivering the Mental Capacity Act and Deprivation of Liberty Safeguards is discharged effectively across the local health economy through the CCG commissioning arrangements. The role is supported by the Head of Quality and Safety who holds delegated responsibility and is executive lead for Safeguarding and the MCA.

5.3 The Head of Quality

The Head of Quality is the executive lead for Safeguarding and MCA/DoLS.

5.4 Designated Professional/Nurse (Safeguarding Adults and MCA & DOLS Lead)

The Designated Professional/Nurse and MCA/DoLS lead will take a strategic and professional lead on all aspects of the NHS contribution to and MCA/DoLS across the CCG's area, which includes all commissioned providers. This includes:

- Ensuring assurance arrangements are in place within the CCGs and provider services.
- Provide professional leadership, advice and support to CCG staff and adult safeguarding leads and MCA professionals across provider trusts/services and independent contractors.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS.
- Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.
- Provide advice and guidance in relation to MCA/DoLS training including standards.
- Ensure quality standards for MCA/DoLS are developed and included in all provider contracts and compliance is evidenced.
- Work closely with the Designated Nurse for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's.
- Ensure that systems are in place within the CCG to make appropriate applications to the Court of Protection
- Work in partnership with the Local Authority to achieve the above aims.

5.5 The CCG Quality Committee

Have a responsibility for development, implementation, review and monitoring effectiveness of these policies and procedures on behalf of the CCG Governing Body, receiving assurance via regular and exception reporting, annual reports and the safeguarding report updates

5.6 CCG Staff.

All staff, including subcontracted, temporary or agency staff, students and volunteers, having contact with patient groups must be familiar with the 5 statutory principles of the MCA. They need to understand DoLS principles and be able to recognise when a person is being deprived of their liberty, follow the legislation as set out in this and national policy having due regard to the Code of Practice. This includes staff undertaking training and maintaining their skills.

All Staff where applicable have a responsibility to ensure that MCA and DoLS is reflected in commissioning processes and contracting arrangements.

6.0 KEY PRINCIPLES AND PROCESSES OF THE MENTAL CAPACITY ACT

6.1 Key Principles

The Mental Capacity Act 2005 (MCA) is underpinned by five key principles set out in the Code of Practice that put the person at the centre of decision making and provides a framework for staff when providing care and treatment:-

Principle 1: **Assume Capacity**:	Every adult has the right to make their own decisions if they have capacity to do so. A person must therefore always be assumed to have capacity unless it is established otherwise.
Principle 2: **Practical steps to maximise decision making capacity**:	A person is not to be treated as unable to make a decision unless all practicable steps to help him/her make the decision have been taken without success
Principle 3: **Unwise decisions**:	A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision
Principle 4: **Best Interest:**	Any act done, or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his\her best interests.
Principle 5: **Least Restrictive Alternative**:	Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the persons rights and freedom of action.

6.2 When is a Mental Capacity Assessment needed?

6.2.1 Decision making capacity refers to a person's ability to make decisions and take actions for themselves, from everyday decisions such as what to eat, to more significant ones such as whether to accept or refuse serious medical treatment.

6.2.2 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.

6.2.3 Capacity assessments refer to a person's ability to make a particular decision at a particular moment in time; they are **not** a blanket judgment on a person's ability.

6.2.4 When a decision needs to be made, but there is concern that the individual may lack capacity then an assessment of the urgency of the decision needs to be made:-

- **When an urgent decision needs to be made:**

  It is possible to treat someone if a clinician reasonably believes a person lacks capacity and that the proposed treatment is necessary to save their life or to prevent a significant deterioration in their condition - do what is

immediately necessary to prevent serious harm and to pass the point of crisis.

The individual's capacity to make a decision needs to considered, and demonstrated in documentation following the delivery of care and treatment that is immediately necessary. Consideration should also be made to keep the individual as informed as possible during the care/treatment as appropriate.

- **The Decision is not urgent:**

  If the person is likely to regain capacity, the decision should be delayed until such a time that the person has the capacity to make the decision for themselves (please see section 6.5 on supporting a person to make their own decisions)

6.3 Who should assess mental capacity?

6.3.1 The individual who assesses a person's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. The person is the decision maker.

6.3.2 This means that different people will be involved in assessing a person's capacity to make different decisions at different times. The decision as to who is the best person to assess for capacity depends on the decision that needs to be made. For most day to day decisions, the carer most directly involved with the person will be best placed to assess the capacity of the person to make the decision at the time it needs to be made.

6.3.3 For more complex decisions and assessments it may be necessary to utilise other specialist professionals when undertaking capacity assessments so that all the relevant information and risks/benefits of the decision to be made can be explained following principle 2 of the MCA.. For example it may be necessary to involve a Speech and Language Therapist or a Tissue Viability Nurse to provide information about the risks and benefits of a particular decision

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Other factors that may indicate other professional involvement might be:-

- The gravity of the decision or its consequence
- Where the person concerned disputes a finding of incapacity
- Where there is disagreement between family members, carers and/or professionals as to the person's capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please them
- Where there is concern that undue pressure or coercion is being placed on the person, their carers or others.
- Where there may be legal consequences to a finding of lack of capacity.

6.4 How to complete a Mental Capacity Assessment: The two stage Test

When there is cause to doubt that a person has capacity to make a particular

decision a two-stage capacity test should be undertaken. The two-stage test comprises of:

1) The establishment that there is a temporary or permanent impairment or disturbance of the mind or brain, and demonstration that this impairment or disturbance means that the person is unable to make the decision at the time that it needs to be made.

2) The functional test – can the person understand, retain, weigh up the information and can they communicate the decision?

Please see appendix 1 for flow chart identifying the mental capacity assessment process and appendix 2 for guidance on completing an assessment

6.5 Supporting people to make their own decisions

6.5.1 When working with a person who needs to make a decision, those working with them must start from the presumption that the person has capacity. It is therefore **responsibility of the assessor** to take all practicable steps to help someone make their own decisions, before they can be regarded as unable to make a decision Please see appendix 3 for examples of practical steps that should be taken.

6.5.2 All information relevant to the decision must be explained to the person, including risks, benefits and consequences. It must include the information likely to be important to the person. This will require a balance to be struck between giving enough information to make an informed decision and too much information or detail which could be confusing.

6.5.3 There are decisions that cannot be made on behalf of others regardless of their capacity:

- Consenting to marriage or a civil partnership, or a decree of divorce on the basis of two years separation or to the dissolution of a civil partnership on the basis of two years separation;
- Consenting to have sexual relations;
- Consenting to a child being placed for adoption or the making of an adoption order;
- Discharging parental responsibilities for a child in matters not relating to the child's property, or
- Giving consent under the Human Fertilisation and Embryology Act 1990;
- A person cannot vote on behalf of a person who lacks capacity.

6.6 The use of restraint

6.6.1 Restraint is being used if a person:

- uses force – or threatens to use force – to make someone do something they are resisting,

  Or

- restricts a person's freedom of movement, whether they are resisting or not'.

6.6.2 Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy. Examples of these include using covert medication, the use of physical force to prevent someone doing something, the use of mechanical restrictions (e.g. bed sides) and the use of verbal threats. This may include having the external door to a unit locked to prevent a patient wandering off into a potentially dangerous situation

6.6.3 In some circumstances restraint is the right thing to do. Restraint can be used:

- If the person consents to it, perhaps because it makes them feel safer
- If it is part of an agreed care plan agreed by all including the person

If the person lacks the capacity to consent, but is acting in a way that may cause harm to themselves or others. In this case, The Mental Capacity Act 2005 identifies that restraint can be used if it is:-

- Necessary to prevent harm to the person **and**
- That restraining act is a proportionate response to the likelihood of the person suffering harm and to the seriousness of the harm **and**
- There is no less restrictive option to meet the need
- If the effects of the restriction amount to a deprivation of liberty, then this must be specifically authorised

6.6.4 Where restraint or a deprivation of liberty may be required, this needs to be included in the persons care plan and all instances of restraint clearly documented.

6.7 Legal Matters

In circumstances such as legal matters, e.g. making a Lasting Power of Attorney, the Solicitor involved may need to decide whether or not the person has sufficient capacity to make the decision. They may ask for an opinion from a doctor or other professional expert.

6.8 Medical Treatment or Examination

When consent for medical treatment or examination is required, the doctor proposing the treatment should decide whether the patient has the capacity to consent or refuse the treatment. In settings such as a hospital, this can involve the multi-disciplinary team. Ultimately, it is up to the professional responsible for the person's treatment to make sure that their capacity has been assessed.

6.9 Care Planning

6.9.1 The five statutory principles of the MCA form a vital part of developing a patient's care plan and should be integral to this process.

6.9.2 Wherever possible individuals who lack capacity should be involved in decisions about their care and treatment as much as they would involve those who have capacity. Where professionals and patients disagree over elements of the care plan the emphasis should be on discussion and compromise where possible.

6.9.3 Care planning for a person who lacks capacity to consent, must adhere to the steps for determining what is in the person's best interests set out in section 4 of

the MCA. This delivers participation by the person and consideration of their wishes, feelings, beliefs and values and consultation with specified others (e.g. carers, attorneys and people nominated by the person) about the person's best interests (Mental Health Act 1982; Code of Practice 2015).

6.10 Children and Young People Aged 16- 17 Years

6.10.1 Most of the MCA applies to people aged 16 years and over, there is an overlap with The Children's Act 1989. For the MCA to apply to a young person, they must lack capacity to make a particular decision through impairment to mental functioning rather than immaturity (in line with the Act definition of capacity described previously). In such situations, either this Act or the Children Act 1989 may apply, depending on the particular circumstances.

6.10.2 There may also be situations when neither of these Acts provides an appropriate solution. In such cases it may be necessary to look to the powers available under the Mental Health Act 1983, or the High Court's inherent powers to deal with cases involving young people.

6.10.3 There are provisions in the MCA not available to 16 or 17 year olds. These are:-

- Making a Lasting Power of Attorney
- Advance decisions to refuse treatment
- Making a Will

6.11 Best Interests of the person

6.11.1 A key principle of the MCA (see principle 4 in section 6.1 of MCA) is that any act done for, or decision made on behalf of a person that lacks capacity must be done in their best interests.

6.11.2 Best interests is the process for making decisions which aims to be objective. It requires the decision maker to think what the 'best course of action' is **for the person.** The decision should not be what the decision maker wants to happen. Instead a best interest decision considers the previous and currently held beliefs, values and expressed wishes of the person who lacks capacity. In effect it is the decision the person is likely to have made if they had the capacity to make the decision.

For more complex Best Interest decisions a balance sheet approach that outlines the pros and cons of making or not making a particular decision, is recommended best practice and is essential for complex decision making or where the case may go to the Court of Protection.

6.11.3 The MCA sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in a particular situation at a particular time (please see appendix 2). Emphasis needs to be also placed on including the incapacitated persons expressed wishes as part of the decision making process.

6.11.4 In establishing best interest it is critical to determine who the decision-maker is. The person who lacks capacity may have a nominated attorney (donee) either with lasting or enduring powers, that relate to the type of decision, welfare or property-

related, to be taken There may be a Court of Protection appointed deputy as decision-maker. It is good practice to check that the person claiming to have decision making powers has the necessary evidence to demonstrate this. In the absence of a deputy or attorney the person requiring the decision will be the decision-maker; for example if a doctor is prescribing a treatment that requires consent, they will be the decision-maker.

6.11.5 For more complex best interest decisions, a balance sheet which outlines the 'pros and cons' of a particular decision is recommended best practice and is essential where the case may go to the Court of Protection

6.12 Recording Assessments of Capacity.

6.12.1 Accurate records must be kept of decisions made in respect of mental capacity and they must demonstrate why certain actions and decisions have been made on behalf of individuals. The protection from liability will only be available if the assessor can demonstrate they have assessed capacity, reasonably believe the person be lacking and then acted in a way that is reasonably believed to be in the person's best interests. Appendix 2 provides a prompt sheet for assessing mental capacity.

6.12.2 A form need not always be used as in most cases assessment of capacity will take place on a regular, more informal level, related to the care and support of the person.

6.12.3 However there may be serious decisions that may need to be made on a person's behalf that it is believed may lack the mental capacity. These situations could create some legal challenge and it is particularly important that clear documented evidence of the assessment of capacity, is completed and recorded in the person's records, including:

- The decision is about serious medical treatment;
- The decision concerns longer term accommodation changes;
- There is a lack of concurrence about whether or not the person lacks of has capacity;
- There is an intention to refer to the Independent Mental Capacity Advocate;
- There is a need to have a specific record of the assessment and such a form would be useful
- There are concerns about conflicting opinions (e.g. between professionals, carers, the person being assessed).

6.13 Safeguarding Adults

6.13.1 This policy should be read in conjunction with the Safeguarding adults Multi-agency policy and procedures for West Yorkshire and North Yorkshire and York 2015.

6.13.2 People who lack capacity are amongst the most at risk of abuse and/or neglect. It is important to recognise that where a person's ability to make some decisions for themselves is impaired, the decisions they are able to make, become more important.

6.13.3 Mental capacity may need to be considered in cases where adult abuse is suspected or proven. A person with capacity will be able to make a decision about their future care and support, even if this means that they wish to remain within an abusive environment. If however a person in an abusive situation lacks capacity, then professionals will need to make a decision on their behalf based on that person's best interests. This may mean a complex set of circumstances will need to be considered, previously expressed wishes and feelings, the effects of the person remaining within the abusive environment and the effects of removing them from the environment. The wider social aspects of a person's circumstances must be considered when determining what is in his or her best interests.

6.12.4 A person who wilfully neglects or ill-treats a person who lacks capacity can be prosecuted under section 44 of the MCA which carries a custodial sentence. Since the introduction of the Act there have been a number of successful prosecutions.

6.14 Lasting Power of Attorney (LPA)

6.14.1 The MCA makes provision for the creation of Lasting Powers of Attorney. Under this arrangement a person can nominate someone to have power of attorney over their affairs in the event that they no longer have capacity, in relation to:

- Health and welfare (including care and treatment), and
- Finances and property.

6.14.2 The nominated person, or donee, must be regarded as having the same decision-making powers as the person themselves would exercise if they had capacity. These might concern areas of specific or general decision-making.
There are safeguards concerning the person's capacity at the time of commencement of the LPA, and safeguards about decisions that the donee makes which have to be in the best interests of the subject.

LPAs are only valid when they are registered with the Public Guardian. The registered LPA will bear an authorised stamp indicating whether it is a Health and Welfare or Finances and Property LPA or both. Alternatively for the office of Public Guardian can verify the person if paper copies of authorisation is not available at:-

Web site: www.guardianship.gov.uk
Tele: 0845 3302900
E-mail: custserv@guardianship.gsi.gov.uk

6.15 Court of Protection (COP)

The Court of Protection is a specialist court existing under the provisions of the MCA to deal with all issues relating to people who lack capacity to make specific decisions. The Court has powers of adjudication and will:-

- Make declaration about whether or not a person has the capacity to make a particular decision
- Make declarations about the lawfulness, or otherwise, of an act done or yet to be done, including decisions on serious health care issues and treatment
- Make single orders, individual decisions about the property and financial affairs, or about the health and welfare of a person who lacks capacity.

- Where there are very complex and difficult decisions to be made, the COP can make these. Moreover there are certain decisions that can only be made by the COP e.g. sterilisation of a person.
- See also section 7.8 for COP role in Deprivation of Liberty

The court has the authority to appoint deputies to make decisions for a person who lacks capacity in complex or disputed cases, and where a single determination is not possible.

6.16 Advance Decisions to Refuse Treatment (See Chapter 9, MCA Code of Practice)

An Advanced Decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

An advance decision can be over-ridden by the Mental Health Act 1983 but only as regards treatment for your mental illness and professionals must still have regard to the advance decision that has been made.

CCG staff responsible for treatment and care, for example continuing health care staff, must be aware of the responsibilities of staff for receiving and recording Advance Decisions whether written or verbal. They must be able to establish the validity of existing Advance Decisions whether they are relevant for a service user given their current situation.

6.17 Independent Mental Capacity Advocates (IMCA)

6.17.1 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. The IMCA's role is to understand and advocate for the person's current and previously expressed wishes and feelings.

6.17.2 The MCA imposes a duty on CCGs and local authorities to instruct an IMCA for incapacitated people who have no relatives, friends or unpaid carers in the following circumstances:

a) Where there is a proposal to provide serious medical treatment, as described below, with the exception of treatment provided under part 4 of the Mental Health Act, for a person who lacks capacity and there is no one apart from a professional or paid carer for the doctor to consult in determining what would be in the patient's best interest. Part 4 of the Mental Health Act (MHA) relates to the treatment of detained patients

b) The CCG/Local Authority proposes to provide accommodation in hospital for a period of more than 28 days or in a care home for more than 8 weeks, for a person who lacks capacity

c) The CCG/ Local Authority propose to change the accommodation of someone who lacks capacity to another hospital for a period of more than 28 days or a care home for more than 8 weeks. This does not include people who are being cared for under the MHA, except post-discharge arrangements made under Section 117 of the MHA.

d) The local authority proposes to provide or change residential accommodation for more than 8 weeks continuously. This only applies to accommodation provided under the National Assistance Act and Section 117 of the MHA by a local authority acting under the NHS and Community Care Act.

6.17.3 The duty to instruct an IMCA does not preclude intervention where it is immediately or urgently necessary.

6.17.4 When referring a person to another agency/department for further assessment/treatment, a referral to the IMCA Service should be made at the same time if the person is likely to require their services for future decision making.

7.0 KEY PRINCIPLES OF THE DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS 2009)

7.1 The Deprivation of Liberty Safeguards (DoLS) came in force in April 2009. The amendment tackles human rights incompatibilities by introducing specific safeguards for people.

7.2 DoLS protect people who are 18 years and over who **lack** capacity (see section 7.6 for those under 18 years of age) to make decisions about treatment or care, and who after all other avenues have been explored need to be cared for in a particularly restrictive way, in a particular place in order to provide care and/or treatment. For example, some people who have dementia, a mental health problem (not detained under the Mental Health Act) or a significant learning disability. The aim of the safeguards is to:

- Provide safeguards for people who lack capacity to decide where to be accommodated for care/treatment
- Ensure people are given the care they need in the least restrictive way,
- Prevent decisions being made to suit the home or hospital rather than the needs of the adult at risk
- Entitle people to take proceedings by which the lawfulness of a deprivation will be decided speedily by a court and release ordered if the deprivation is seen as unlawful.

7.3 Deprivation of Liberty in hospital and care homes

DoLS cover patients in hospitals (including hospices) and people in care homes whether placed under public or private arrangements.

7.4 A DOLS authorisation cannot be used to authorise a deprivation of liberty taking place in a children's home. The Court of Protection can authorise the deprivation of a person's liberty from the age of 16. Under the age of 16 years, a deprivation of liberty must be authorised under inherent jurisdiction of the High Court.

7.5 Deprivation of Liberty in domestic settings

7.5.1 A deprivation of liberty can occur in domestic settings where the state is aware of or responsible for imposing such arrangements

7.5.2 This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements it must be authorised by the Court of Protection.

7.6 Deprivation of Liberty: Children and Young People

7.6.1 The criteria for a deprivation of liberty (see below) is the same for children and young people as it is for adults. Children under the age of 16 who live with their parents would usually not fall into the remit of deprivation of liberty legislation as a parent is able to consent to arrangements on their behalf.

7.6.2 Parents cannot consent to a deprivation of liberty for those children aged 16-18 years.

7.6.3 Parents may consent to a deprivation of liberty for their child who is under the age of 16 years, except in circumstances where the parent **does not have** parental responsibility.

7.6.4 Where a child is subject to care arrangements and the Local Authority has parental responsibility for the child, the Local Authority **cannot** consent to a deprivation of liberty on behalf of the child. In these circumstances an application needs to be made (either inherent jurisdiction of the High Court order for those under 16 years old or to the Court of Protection for 16-17 years old children).

7.6.5 The law concerning a deprivation of liberty for children and young people is still developing and it is therefore important that advice is sought.

7.7 How to assess if a person is being deprived of their Liberty: Six conditions

7.7.1 Six key conditions must be met to consider if a person is being deprived of their liberty:-

- The person is 18 or over in a hospital of Care Home and potentially any age in a community setting
- The person is suffering from a mental disorder.
- The person lacks capacity to decide for themselves about the restrictions which are proposed so they can receive the necessary care and treatment.
- The restrictions would deprive the person of their liberty.
- There is no other existing authority to deprive the person of their liberty : eg they are not deprived under the Mental Health Act,
- The deprivation is in the person's best interests.

7.7.2 The Acid Test to determine a deprivation of Liberty: The Judgment of the Supreme Court 2014

The Supreme Court in 2014 response to a specific case (*P v Cheshire West and Chester Council* and *P&Q v Surrey County Council – see section 9 for reference*), identified two key criteria to assessed if a person may be being deprived of their liberty – the 'acid test.

The Acid Test

Is the person subject to continuous supervision and control?

AND

Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave.)

All three aspects are necessary: so if a person is subject both to continuous supervision and control and not free to leave **they are deprived of their liberty**. It must also be noted that continuous supervision and control does not necessarily need to amount to 24 hours a day.

7.7.3 The following factors are no longer relevant to the decision that a person is being deprived of their liberty:

- the Person is compliant or does not object
- the placement is relative normal, and
- the reason or purpose behind or quality of a particular placement.

7.8 Applications for DoLS

7.8.1 There are many situations where it is necessary to deprive someone of their liberty in order to protect them from harm in their best interest. Having this deprivation authorised is a legal requirement and provides the person with safeguards to ensure that their human rights are upheld.

7.8.2 Where responsible staff within a Managing Authority (Care Home or Hospital) think there is a need to deprive someone of their liberty or they may need to deprive someone in the future, they have to ask for this to be authorised by a *Supervisory Body*. They can do this up to 28 days in advance of when they plan to deprive the person of their liberty.

7.8.3 For care homes and hospitals the Supervisory Body is the local authority where the person is ordinarily resident. Usually this will be the local authority where the care home is located unless the person is funded by a different local authority.

7.8.4 The Managing Authority must fill out a form requesting a standard authorisation. This is sent to the supervisory body which has 21 days to decide whether the person can be deprived of their liberty. The authorisation process involves independent assessments and these inform the Supervisory Body's decision to either grant or not grant the authorisation. There are 6 criteria (see 7.6.1) that must be assessed and fulfilled for the authorisation to be granted.

7.8.5 The Managing Authority can deprive a person of their liberty for up to seven days using an urgent authorisation in circumstances where the care arrangements mean the person is already being deprived of their liberty.. It can only be extended (for up to a further seven days) if the supervisory body agrees to a request made by the managing authority to do this.

7.8.6 When using an urgent authorisation the Managing Authority must also make a request for a standard authorisation and have a reasonable belief that a standard authorisation would be granted.

7.9 CCG Responsibilities

7.9.1 Those staff employed by the CCG and practice members who visit, assess, treat, monitor and review patients residing in registered care establishments and or residing in hospitals should be aware of the Deprivation of Liberty Safeguards.

7.9.2 Where CCG staff are aware of a potential Deprivation of Liberty in a domestic setting, they must explore and seek authorisation by the Court of Protection for the deprivation (starting first with the person's Mental Capacity Assessment to make the decision, the least restrictive option for the person and a Best Interests process adopted)

7.9.3 The Court has a streamlined process to authorise such deprivation. The Re X procedure is designed to enable the court to decide applications for a court-authorised deprivation of liberty on the papers only, without holding a hearing, provided certain safeguards are met. Those safeguards include ensuring that:

- The person who is the subject of the application and all relevant people in their life are consulted about the application and have an opportunity to express their wishes and views to the court.
- The person who is the subject of the application has not expressed a wish to take part in the court proceedings
- The person who is the subject of the application and all relevant people in their life do not object to the application.
- There are no other significant factors that ought to be brought to the attention of the court that would make the application unsuitable for the streamlined procedure.
- Where this criteria is not met an application to the Court of Protection for an oral hearing must be made.

7.10 How to report unauthorised deprivations

7.10.1 If anyone is concerned that a Hospital of Care Home, has or may be being deprived of their liberty and a DoLS authorisation is not in place, the person should report their concerns:-

- Firstly the Hospital or Care Home should be advised of your concerns, to allow the organisation to review their arrangements
- If after a reasonable period of time (approximately 24 hours) there is still concern that an unauthorised deprivation is continuing by the Care Home or Hospital, then inform the Local Authority DoLS team who are the Supervisory Body.

7.11 Safeguarding Adults: Raising a Safeguarding concern for a Deprivation of Liberty

7.11.1 A Deprivation of Liberty of a person who does not have capacity to consent to care and treatment should always be dealt with urgently via the authorisation process.

7.11.2 Any unauthorised deprivation of a person may amount to abuse, and in these cases a safeguarding concern/alert may need to be raised via the agreed Multi-agency Safeguarding Adults Procedures.

7.11.3 In deciding whether safeguarding concern/alert a decision needs to be made as to whether the response is proportionate to the nature of the concern, and in the best interests of the adult at risk. Examples of where a concern/alert may need to be raised include:-

- Where a person is deprived of their liberty without appropriate authorisation and this is overly restrictive or being addressed in a timely manner
- Where a person is deprived of their liberty without authorisation and experiences harm, including physical, emotional psychological distress or the loss of fundamental human rights.
- Where the Managing authority (e.g. Care Home or Hospital) repeatedly or seriously fails in its responsibilities to seek authorisation for deprivation of liberty of patients, or fail to end a deprivation of liberty after it is no longer required,

7.12 Death of a Person Under a DoLS/COP Authorisation

7.12.1 When a person dies and is subject to a DoLS authorisation or an application has been made but not yet processed, whether the authorisation is by the Supervisory Body (the Local Authority) or the Court of Protection the coroner **must be** informed of the death.

7.12.2 The reason for this being that Coroners must currently complete inquests when someone dies in custody or other state detention, even if the death is from natural causes. A person's under a DoLS or Court of Protection order for deprivation of liberty is seen to be legally in a 'state of detention'.

7.12.3 The responsibility to notify the Coroner lies with the Managing authorities (care homes, and hospitals). However it is seen as best practice to ensure that medical staff (including General Practitioners) caring for the person who has dies has a DoLS for COP in place, to ensure death certificates are not issued prior to Coroner inquest processes

8.0 DEFINITIONS AND ABBREVIATIONS

8.1 Definitions

Advance decision:	Decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision.
Best Interests:	Any act done or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the MCA (2005) sets out a non-exhaustive checklist. Please also see appendix 4
Best Interests Assessor	Best Interests Assessors (BIAs) are authorised practitioners whom complete Best interests assessments in accordance with the MCA whom have undertaken further and continuous training to maintain their competence.
Court of Protection	The MCA 2005 created this court which has jurisdiction relating to the whole of the Act.
Decision-maker	Responsible for deciding what is in the Best Interests of a person who lacks capacity.
Deprivation of Liberty Safeguard	A legal authorisation that allows a managing authority to deprive someone who lacks mental capacity of their liberty.
Enduring power of attorney	An **enduring power of attorney** is a legal agreement that enables a person to appoint a trusted person - or people - to make financial and/or property decisions on their behalf. An **enduring power of attorney** is an agreement made by choice that can be executed by

	anyone over the age of 18, who has full legal capacity
Informed	Legally the individual needs to be advised of:- 1. Proposed risks and downsides of decision 2. Benefits of decision 3. Alternatives to the decision (and the risks, downsides and benefits of each alternative) 4. Material Information (information that patient would likely attach significance too because of their unique personality and circumstances.
Lasting Power of Attorney (LPA):	Another person appointed to act on their behalf of a person in relation to decisions about the person's financial and/or health and welfare (including healthcare) at a time when they no longer have capacity.
Mental capacity	The ability of an individual to make a specific decision about specific aspects of their life.
Managing Authority	The organisation responsible for the care home or hospital applying for the DoLS authorisation
Supervisory Body	The Local Authority which covers the persons normal place of residence. Local Authorities are responsible for considering a DoLS request, arranging the required assessments and authorising (or not) a DoLS authorisation.

8.2 Abbreviations

CCG: Clinical Commissioning Group

COP: Court of Protection

DoLS: Deprivation of Liberties Safeguards

LPA: Lasting power of Attorney

MCA: Mental Capacity Act

MHA: Mental Health Act

NHS: National Health Service

CCCG: NHS Calderdale CCG

9.0 REFERNCES AND RECOMMENDED FURTHER READING

9.1 References

In developing this policy, account has been taken of the following statutory guidance:

NHS England (2014) Mental Capacity Act - A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commisioning for Compliance. http://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf

Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to Supplement Mental Capacity Act 2005. London. TSO http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/pr

od_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. London. TSO http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

9.2 Recommended further reading

The following links provide access to further reading including to current case law:-

http://www.39essex.com/tag/mental-capacity-guidance-notes/

http://www.39essex.com/tag/mental-capacity-newsletter/

http://thesmallplaces.blogspot.co.uk/

http://www.mentalcapacitylawandpolicy.org.uk/

http://www.mentalhealthlaw.co.uk/Main_Page

10.0 Prevent

All healthcare employees have a role to play in protecting and supporting vulnerable individuals especially those who may be vulnerable to radicalisation. Prevent aims to stop people becoming terrorists or supporting terrorism. In carrying out their day to day work colleagues may notice unusual changes in the behaviour of someone (patient, carer or employee) which are sufficient to cause concern. It is important that if anyone has a cause for concern, they contact their line manager or Prevent Lead in order to discuss if any further action is needed, this may include referral to the Channel process.

11:0 APPROVAL AND RATIFICATION OF THIS POLICY

This Policy will be approved by the CCG Quality Committee and ratified by the CCG Governing Body

12.0 DISSEMINATION AND IMPLEMENTATION

This policy upon ratification will be made available on the CCG Safeguarding intranet site. This document will be entered onto the corporate document database.

It is the responsibility of managers to ensure that this policy is adhered to by all staff and is explained to new staff at local induction. Failure to adhere to this policy may result in disciplinary action.

13.0 REVIEW AND REVISION ARRANGEMENTS

At the time of writing this policy it is recognised that current case law is influencing and changing current legal requirements. Therefore this policy has been written with reference to current case law (at the time of writing), and is based upon the codes of practice for MCA DoLS legislation and upon Human Rights legislation.

This Policy will be reviewed every three years unless there is landmark case law r new significant national or local legislation or guidance that necessitates an earlier amendment, by the CCG lead for MCA and Deprivation of Liberty Safeguards

14.0 TRAINING AND EDUCATION

The CCGs will enable employed staff (temporary and permanent) to participate in MCA and DoLS training relevant and proportionate to their role to meet the requirements of commissioning of services. Training can be accessed from a variety of sources, including training offered by the Kirklees Safeguarding Adults Board.

15.0 STANDARDS

The CCG combined Safeguarding Adults and Children's Policies contain minimum standards for MCA and DoLs requirements from Providers

The CCG's Safeguarding Policies (with required standards for MCA AND DoLS Practice) can be found at the relevant CCG internal websites.

16.0 MONITORING COMPLIANCE

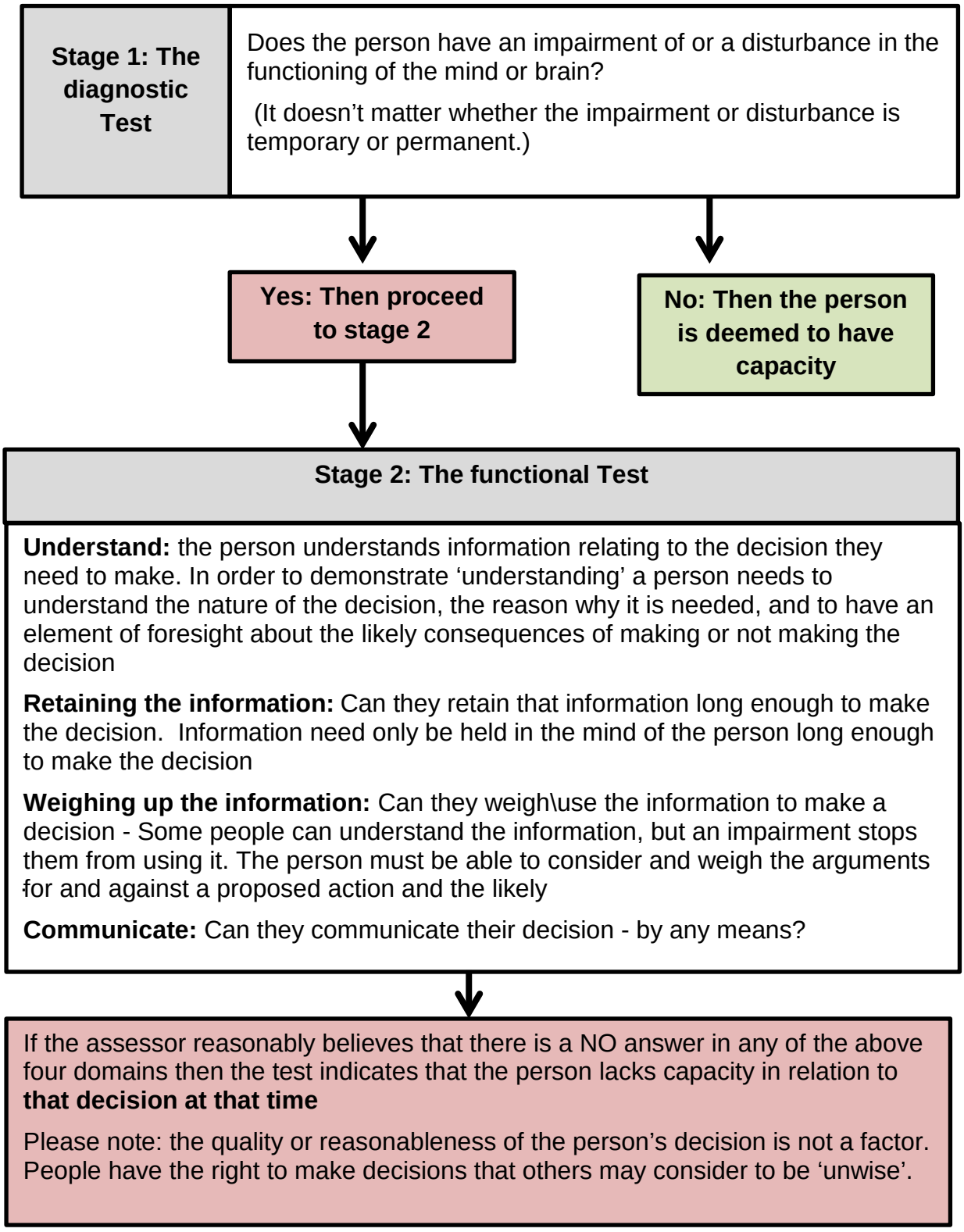
The CCGs will seek assurance from providers on compliance with the MCA DoLS legal requirements through various mechanisms including within the national NHS contacts and the CCG Safeguarding Standards document identified with the CCG Safeguarding Policy.

17.0 EIA

An Equality Impact Assessment has been completed and is available for review in appendix 5.

Appendix 1

Flow chart for assessing mental capacity



Appendix 2

Guidance for completing a Mental Capacity Assessment

Each stage must be **clearly documented** within the individuals' records to ensure adherence with the code of practice and ensure clarity/transparency of the assessment:-

Key stage/principle	Comments
1. Presumption of capacity	It must be presumed that everyone has capacity unless there is something to suggest that decision–making is compromised. So be clear as to why a mental capacity assessment is being undertaken and remember capacity must be based on current presentation and not solely on diagnosis.
2. The Decision	It must be clear what the capacity assessment is in respect of – i.e. what decision is to be made. *Remember all Capacity assessments are decision specific (and time specific)*
3. Information	All the information that is relevant to the decision must be given to the individual including: – • The risks and downsides • The benefits • All alternatives (and the risks and benefits of each) • All Material Information is provided to the individual - *information that the individual might likely attach significance too because of their unique personality and circumstances*
Only when the first three key stages of the assessment have been completed remembering that all support must be given to the individual to help them understand the information, can the next stage of the assessment progress	
Key stage/principle	**Comments**
4. Does the individual have an impairment/ disturbance of the mind or brain?	**If no –** Stop the assessment – the individual has capacity! **If yes –** is this permanent or temporary - can the decision be delayed?
5. Understanding the information	Has the individual understood the information relevant to the decision? *(see below 'tips for assessing')*
6. Retaining the information	Has the individual retained the information relevant to the decision? *(they need to be able to retain the information for long enough to make a decision) - see below 'tips for assessing'*
7. Weighing – up the information	Is the individual able to weigh –up the information? *'see below 'tips for assessing'*
8. Communicating the decision	Is the individual able to communicate their choice for the decision?

Tips for assessing stages 5-7: ask the individual to repeat back in their own words the information, what decision they might want to make and the reason for that decision.

If the individual fails on any point from 5- 8:- Then on the balance of probabilities they lack capacity to make the specific decision**. * Remember:** individuals can make unwise choices unless the reason that the individual gives for the decision is so extraordinary that a reasonable man would not give them.

Appendix 3

Practical steps to supporting people to make their own decisions

This list is not exhaustive but provides examples of practical steps that must be taken to support people:-

1. Relevant information is provided in a language the person will understand
2. Use of signing, translation services, or Makaton should be considered
3. It may be more useful to communicate in the person's first language
4. The person may find it easier to make a decision in a different place or at a different time (for example at home instead of in a clinic or the person may function better in the morning than the afternoon)
5. A period of education may be required
6. Is advice from a specialist required to help the person make the decision (e.g. speech and language therapist, financial or legal advisor)
7. Can relatives, friends or carers help? They may have important advice on how the person communicates, or may be able to communicate better with the person
8. Some people may find it easier to communicate at certain times of the day
9. Is medication affecting the person's ability to communicate?

Appendix 4

Checklist for consideration in Best Interests Processes

Best Interests Checklist:

Consider:

- All the relevant circumstances.
- A delay until the person regains capacity.
- Involving the person in the decision making as much as possible. Even though it has been determined that the individual lacks capacity to make this decision, their views need to be considered and the process needs to include them as far as possible.
- The person's past and present wishes, beliefs and values that would influence their decision making if they had capacity and other factors the person would take into consideration if making their own decision.
- Any advance statements made.
- The beliefs and values of the individual.
- Taking into account views of family and informal carers, IMCA's and take in to account what it is believed the incapacitated person would take in to account if they were making the decision.
- Taking into account views of the Independent Mental Capacity Advocate (IMCA) or other key people.
- Showing it is the least restrictive alternative or intervention.
- The decision must not be made merely on the basis of the person's age or appearance.
- The person's behaviour should not lead to assumptions about what might be in their best interests.
- If the decision concerns life sustaining treatment, the decision must not be based on a desire to bring about death.
- Taking into account the views of anyone caring for the person or interested in their welfare – this includes paid and informal carers. The decision maker must consult if possible anyone who has a Lasting Power of Attorney or is a deputy appointed by the Court of Protection.

Using the Best Interest Checklist:

- The decision maker is responsible for the decision.
- The decision maker must consult and involve others as much as possible.
- The decision maker does not have to follow the views of anyone else, but would need a good, reasoned argument for ignoring the views of others.
- Do not avoid discussion with people who may disagree with the decision maker. Involving people who might disagree with the decision in the process can often reassure them of how the decision is being made and can allow them to accept the final decision.
- There is no prescribed method of consultation. The decision maker could see family members together with the person being assessed if appropriate but this may not be helpful.
- There is no hierarchy of whose views within a family should carry more weight. The concept of 'next of kin' does not mean anything under MCA.
- A best interest decision needs to consider a holistic assessment of the individual. For instance, what would be clinically indicated may not be in someone's best interests when their past views are considered or the possible effects of the treatment are considered. If a move from one care home to a different one is being considered it could be that someone's needs might be better met in a different setting, but consider as well the effects of the stress of a move or the distance from family contact.
- Under the Deprivation of Liberty Safeguards there is a specialist role for experienced staff who receives extra training of: 'Best Interests Assessor'. This role only relates to decisions taken under DoLS and does not apply to best interests decisions made under MCA.

Best Interest: How to formalise a best interest decision

- A best interest decision can be made and recorded by the decision maker
- It is not necessary to hold a Best Interests Meeting to formalise the decision making. However a Best Interest Meeting may be useful to gather the views of others in order to come to a relevant decision.
- It is always necessary to record the best interest's decision.
- If you are using the MCA capacity assessment form the best interest's decision should be recorded on this form. It can otherwise be recorded within a care plan or within notes. (The best interest tool forms part of the capacity assessment tool, provided in the appendices)

Appendix 5

Equality Impact Assessment

Title of policy	Mental Capacity Act and Deprivation of Liberties Safeguards Policy	
Names and roles of people completing the assessment	Clare Robinson Designated Nurse Safeguarding Adults Sarah Mackenzie –Cooper Equality and Diversity Manager	
Date assessment started/completed	22.4.16	09.05.16

1. Outline	
Give a brief summary of the policy	The policy aims to advise CCG staff of the principles and requirements set out in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS) 2009, and the associated Codes of Practice. The Policy applies to all staff working for CCG. The policy also identifies that as part of commissioning processes, the commissioned health providers will also be required to demonstrate that there staff adhere to the requirements of the MCA/DoLS legislation
What outcomes do you want to achieve	Staff are clear on their responsibilities and what actions they have a responsibility to take. The policy also seeks to empower and protect people who may not be able to make their own decisions. To ensure the legalities and statutory responsibilities within the Mental Capacity Act and DoLS and associated legislation are embedded into clinical practice.

2.Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations			
	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?** Policy has a	**What action will be taken to address any negative impacts or enhance positive ones?**

Age	No, but there is potential that older people may be affected due to reduced capacity.	positive impact on staff and services users as staff will understand their responsibilities and what actions they need to take. Staff working with patients need to ensure that they are aware and adhering to the MCA/DoLS codes of Practice The Policy also has a positive impact to support the CCG in discharging its duties and responsibilities as a commissioner, to commission services that are MCA DoLS compliant	The policy guides action so should be age neutral
Carers	There is a potential impact for Carers who may not understand the requirements of the legislation		Line Managers of CCG staff who deal with Patients and Carers will need to ensure that staff have read and understand this policy and understand their responsibilities CCG Staff awareness of their responsibilities is critical, and staff will be signposted to this policy and to the codes of conduct.
Disability	There is a potential positive impact on those with disability e.g. Learning Disability or brain injury to ensure that all are responded according to the law, which protects those with capacity to make their own specific decisions, and provides safeguards for those who don't have the capacity to make specific decisions		For commissioned providers this will be monitored via contracting processes and will be required to deliver assurance of their adherence to the legislation and safeguarding standards.
Sex	No		
Race	There is a potential for a negative impact if policy not followed regarding interpreters where English is not spoken or is a second language		The policy is clear on the requirements for interpreters.
Religion or belief	No		
Sexual orientation	No		
Gender reassignment	No		
Pregnancy and maternity	No		
Marriage and civil	No		

partnership			
Other relevant group	No		
If any negative/positive impacts were identified are they valid, legal and/or justifiable? Please detail.			

4. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Policy will be reviewed in one year unless there is landmark case law or national significant changes that would necessitate an earlier review.		
Lead Officer	**CCG MCA lead**	**Review date:**	**April 2019**

5.Sign off			
Lead Officer	Luke Turnbull: Designated Nurse Safeguarding Adults		
Director	Penny Woodhead Head of Quality & Safety	**Date approved:**	