Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Version 2

Ratified by NHS Warrington Clinical Commissioning Group Quality Committee

Date Ratified July 2015

Author(s) Julie Ryder – Designated Nurse Adult Safeguarding

Responsible Committee Quality Committee

Date Issued July 2015

Review Date May 2017

Policy Number

Intended Audience All CCG Staff

Impact Assessed Yes

Applicable Statutory, Legal or National Best Practice Requirements

Safeguarding Essential Standards- CQC Care Quality Commission
Safeguarding Vulnerable People in the reformed NHS –NHS Commissioning Board
Mental Capacity Act (2005)
MCA/DoLS (2007)
Safeguarding Audit Tool 2014-2015
The Care Act 2014
## Version Control Sheet

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<td>Julie Ryder-Designated Nurse</td>
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<td>Review</td>
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**Equality Impact Assessment**
- Completed by Julie Ryder
- Date

**Sponsor approval**
- By
- Date

**Issue Date:**
- May 2015

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**Document Name:**
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy

**Version No:**
- 2

**Author:**
- Julie Ryder

**Lead Director:**
- Dr A Davies
Values

1. Warrington Clinical Commissioning Group (CCG) works in partnership to develop excellent health services for the people of Warrington, contributing to a healthier Warrington for all. The CCG focuses on Warrington patients and strives to be different, working in partnership with local people. The CCG also recognises and works within its external constraints whilst always striving for quality. Warrington CCG is committed to a set of values that promotes:-

- Excellence
- Valuing Patients and Partner
- Accountability
- Partnerships in everything
- Honesty and Integrity
- Openness and transparency
- Courage

Background

2. Warrington CCG is responsible for commissioning high quality services for patients in Warrington and has a particular duty and commitment to those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to illness, disability, frailty etc.

3. Warrington CCG is accountable for ensuring its own safeguarding adults’ structures and processes, and those in agencies from which we commission services meet the required standards. To ensure that providers are compliant with contractual agreements and The Care Quality Commissions Standards for Safeguarding, it essential that CCG’s are equipped with policies, training and process around Acts of Law which help protect those most vulnerable in society. Those who often present as most vulnerable being people who lack capacity to make decisions about their own care, treatment, finances and residency.

4. Warrington CCG has an overarching commissioning safeguarding children and adult policy which incorporates service delivery standards and should be read in conjunction with this policy

5. It has been made clear through the mandate from the Government to NHS England, March 2013 that the NHS improves safeguarding practice in the NHS, reflecting also the commitment to prevent and reduce the risk of abuse and neglect of adults. Additionally the NHS Constitution through the Health and Social Care Act 2012 provides a statutory duty to continually seek to improve the quality of care to patients and to treat individuals with dignity and
respect in accordance with their Human Rights. With the introduction of the Care Act 2014, safeguarding adults now has statutory footing

**Introduction**

6. The purpose of this policy is to provide Warrington CCG employees with guidance around their responsibilities to follow the Mental Capacity Act and Deprivation of liberty Safeguards and direct them to wider reading available at the Office of Public Guardian:

www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

7. The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves. Regard for the Mental Capacity Act helps organisations to protect vulnerable groups within a legal framework which is supported by a Code of Practice.

8. It 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.

9. Everyone working with or caring for an adult over the age of 16 who may lack capacity to make a specific decision must comply with the Mental Capacity Act, irrespective of whether the decision relates to a life changing event or an everyday matter.

10. This policy details the roles and responsibilities of Warrington CCG as a commissioning organisation, with respect to mental capacity issues.

11. Various legislation and guidance is published that is relevant to this policy which employees should be familiar with and refer to as required:

   - The Care Act 2014
   - The Mental Capacity Act 2005
   - The Mental Capacity Act: Code of Practice
   - Deprivation of Liberty Safeguards (DoLS): Code of Practice
   - The Mental Health Act 1983 (as amended 2007)
   - The Human Rights Act 1998
   - The European Convention on Human Rights
   - The Care Standards Act 2003
Objective

12. Warrington CCG has a statutory responsibility for:-

- Ensuring that the organisations from which it commissions services provide a safe system which safeguards vulnerable children and adults, including adults who lack mental capacity.
- Ensuring it commissions MCA compliant care and will ensure that providers meet their statutory responsibilities to those patients/customers who access services.
- Ensuring that all staff employed by WCCG are aware of their responsibilities under the MCA and that their staff operate at all times in accordance with the MCA and the accompanying code of practice.
- Ensuring that Warrington CCG undertake yearly safeguarding adults and children’s mandatory e learning training which incorporates Mental Capacity Act Training.

Scope of the Policy

13. This policy applies to all employees of Warrington CCG, particularly those CCG Clinical Staff who work in Continuing Health Care who have responsibility for commissioning NHS Continuing Healthcare and NHS-funded Nursing Care.

14. This policy can be adopted by Warrington Primary Care, General Practices

15. This policy should be read in conjunction with Warrington’s Multi-Agency Safeguarding Policy and Warrington Council’s MCA/DoLS Policy which may be obtained via the Warrington Councils web site

16. The MCA Code of Practice should also be referred to as a supportive document

17. Where Warrington CCG is identified as the co-ordinating commissioner it will notify associate commissioners of a provider’s non-compliance with their responsibilities with respect to mental capacity issues, or of any serious untoward incident that relates to mental capacity issues.
Roles and Responsibilities

CCG staff including GP Member Practices

18. The Chief Clinical officer for Warrington CCG ensures that promoting the safeguarding of adults, (including The Mental Capacity Act), is discharged effectively across the whole local health economy through the organisations commissioning arrangements.

19. The Mental Capacity Act lead for Warrington has joint employment across Warrington Borough Council and Warrington Clinical Commissioning Group. The lead has a responsibility to ensure that the principles of MCA are incorporated into practice across the Warrington Borough. The Mental Capacity Act and Governance Lead can be contacted At Warrington Council, Newtown House on the following Email address: pdavidson@warrington.gov.uk

20. The Designated Nurse for Safeguarding Adults has lead responsibility for the CCG to provide the leadership; skills; expertise and ability to steer the adult safeguarding agenda and ensure compliance with the Mental Capacity Act. The Designated Nurse for adults can be contacted at WCCG Headquarters on the following Email address: julie.ryder@warringtonccg.nhs.uk

21. The Designated Nurse for Children has lead responsibility for the CCG to provide the leadership; skills; expertise and capacity to safeguard children and will facilitate compliance with the Mental Capacity Act. The Designated Nurse for children can be contacted at Warrington Clinical Commissioning Group on the following Email address Pauline.owens@warringtonccg.nhs.uk.

22. “The CCG lead for safeguarding adults needs to have a broad knowledge of healthcare for older people, people with dementia, people with learning disabilities and people with mental health condition. The CCG lead should be embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice” (NHS England 2015).

23. General Practice members are managed through the NHS England Local Area Team; however the CCG will work with all member practices to support them in ensuring compliance with the law and good practice around the MCA, until further guidance, support and training is provided through Education for England.
24. In order to discharge its responsibilities with respect to the Mental Capacity Act Warrington CCG will:

25. Ensure that all staff employed by the CCG is aware of their responsibilities with respect to the MCA and ensure that staff and member practices operate at all times in compliance with the act and the accompanying code of practice.

26. Ensure that Staff are aware of patient groups or circumstances when actions under the Mental Capacity Act may be necessary due to an impairment or disturbance of the mind or brain. Any treatment decisions that follow an assessment that a person lacks capacity must be fully documented to ensure the best interest process has been followed.

27. Ensure that staff undertakes training; including attending regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the Mental Capacity Act.

28. Warrington CCG Senior Managers and Clinical Leads will Identify employees who because of their particular role/job description require extra training above the mandatory e learn module and will ensure that this is highlighted within their Personal Development Reviews and coaching arrangements and the necessary training be facilitated (Warrington Borough Council (WBC) provides Multi-agency training for professionals encompassing the MCA/Deprivation of Liberty Safeguards).

29. The CCG will ensure that its employee’s understand the principles of confidentiality and information sharing in line with the Mental Capacity Act.

30. Ensure all employees contribute, when requested to do so, to the multi-agency best interest meetings when related to funding of placements, and ensure that training with regard to the mental capacity act and its effective implementation is provided to CCG staff.

31. Develop a clear line of accountability for mental capacity matters, built into internal CCG governance arrangements.

32. The CCG will Engage with local Safeguarding Adults Board (SAB) and be a statutory board member.

33. Work with local agencies to provide joint strategic leadership on MCA and DoLS in partnership with Local Authorities, provider clinical governance teams and safeguarding leads, CQC, and where applicable, the police.

34. Ensure that provider deliver on the NHS standard contract specifically around the compliance with MCA and DoLS legislation and that commissioned
services are supported and contract monitored for compliance with MCA (Using the National NHS England, Safeguarding Audit Tool for monitoring, locally adapted).

35. Ensure that learning from cases where mental capacity has been an issue will be used to inform future commissioning and practice.

36. Ensure that leads for safeguarding adults and mental capacity within the CCG have broad knowledge of healthcare for older people, people with dementia, people with access support and training where learning needs are identified.

37. Ensure that safeguarding and MCA leads work within the local health and social care economies to influence local thinking and practice around MCA.

38. Ensure that best practice around mental capacity is promoted, implemented and monitored both within the CCG and within commissioned provider services.

39. Ensure that the principles of the MCA are embedded into policies/procedures for End of life Care decisions across the Warrington footprint.

40. Ensure that providers have the assessment tools, care planning and pathways in place to assess capacity and carry out best interest meetings.

41. Engage with patients and the public in order to seek their views and ensure that literature/information is available for them to access, which includes easy read material.

Providers / Monitoring

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

43. The Care Quality Commission (CQC) Standards for safeguarding require providers who are regulated to comply with standards around the MCA and have the evidence of organisational compliance ready for inspections that may occur in due course.

44. Providers must ensure that there is clarity as to who holds corporate responsibility for MCA and DoLS functions within the organisation, and that appropriate governance and safeguarding systems are in place to deliver best practice.
45. Providers must be in a position to provide assurance to CCGs that their responsibilities with respect to MCA are being safely discharged.

46. Providers will be audited for MCA compliance using the NHS England Safeguarding audit tool, adapted locally to meet local needs.

47. Providers will be expected at the request of the Designated Nurse at any time to produce reports, audits in relation to Mental Capacity Assessments, best interest documentation/minutes of meetings, and evidence of DoLS applications made and associated care plans.

**Definition**

48. The Mental Capacity Act 2005 defines lack of capacity in the following way: “A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”.

49. A person will be unable to make a decision if they cannot:

   **Understand** the information about the decision to be made.

   **Retain** that information in their mind.

   **Use or weigh** that information as part of the decision-making process, or

   **Communicate** their decision (by talking, using sign language or any other means).

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

51. The Act generally applies to people who are aged 16 or older. There is an overlap with the Children Act 1989. For the Act to apply to a young person, they must lack capacity to make a particular decision (in line with the Act’s definition of lack of capacity. In such situations either this Act or the Children Act 1989 may apply, depending upon the particular circumstances. However, there may also be situations where 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.
Basic Principles of the Mental Capacity Act

52. A person must be assumed to have capacity unless it is established that he/she lacks capacity.

53. A person must not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

54. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

55. Any action taken or any decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.

56. Before any action is taken, or any decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person

Capacity Assessment Tips

Who should assess capacity?

57. Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity – follow the two-stage test.

58. The MCA is designed to empower those in health and social care to undertake capacity assessments themselves, rather than rely on expert testing by psychiatrists or psychologists.

59. However, in cases involving complex or major decisions then the assessor could be a (consultant psychiatrist or psychologist).

60. What and when to record will vary. As a general rule, there is no need to record assessments of capacity around day-to-day decisions. In order to have protection from liability when providing care or treatment, carers must have a reasonable belief that the person they care for lacks capacity to make relevant decisions about their care or treatment.

61. In these circumstances, it is useful to be able to describe the steps taken and have a written record.
62. Professionals are subject to higher standards in terms of record keeping and a formal record will be required to be kept, for example in the patient’s clinical notes if a doctor or a healthcare professional is proposing treatment for someone who lacks capacity. (The assessment tool can be located in the appendices to the rear of the policy).

Best Interest Check List / Documentation

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.
- Taking into account views of 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 person likely to regain capacity? Can the decision wait?
- If the decision concerns life sustaining treatment, the decision must not be based on a desire to bring about death. This states that the MCA cannot be used for the purposes of euthanasia.
- 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 often not necessary to hold a Best Interests Meeting to formalise the decision making.
- 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)
Independent Mental Capacity Advocate (IMCA)

63. The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA).

64. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

65. The IMCA role is to support and represent the person in the decision-making process. Essentially they make sure that the Mental Capacity Act 2005 is being followed.

The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 set out the IMCA's role and functions. These are grouped below into four areas:

1. Gathering information
   - Meet and interview the person (in private if possible).
   - Examine relevant health and social care records.
   - Get the views of professionals and paid workers.
   - Get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person.
   - Find out other information which may be relevant to the decision.

2. Evaluating information
   - Check that the person has been supported to be involved in the decision.
   - Try to work out what the person's wishes and feelings would be if they had capacity to make the decision and what values and beliefs would influence this.
   - Make sure that different options have been considered.
   - Decide whether to ask for a second medical opinion where it is a serious medical treatment decision.

3. Making representations
   - IMCAs should raise any issues and concerns with the decision maker. This could be done verbally or in writing. IMCAs are required to produce a report
for the person who instructed them. In most cases this should be provided to the decision maker before the decision is made.

- People who instruct IMCAs must pay attention to any issues raised by the IMCA in making their decision.

4. Challenging decisions

- In many cases IMCAs will be able to resolve any concerns they have with the decision maker before the decision is made. Where this has not been possible IMCAs may formally challenge the decision-making process. They can use local complaint procedures or try to get the matter looked at by the Court of Protection.

How to contact the IMCA Service

Halton, Knowsley, Warrington & St Helens IMCA
Fax 01744 759 937
Office 01744 451 531
pc-hkwsimca@together-uk.org
Together, Alexandra Business Park, Prescot Rd, St Helens, WA10 3TT

Mental Capacity Act Deprivation of Liberty Safeguards

Defining Deprivation of Liberty

66. The Deprivation of Liberty Safeguards (DoLS) are an addition to the MCA, introduced to provide a statutory framework for the Deprivation of Liberty of people in care homes or hospitals, specifically to prevent breaches of the European Convention on Human Rights 1998 (ECHR) and to prevent authorities taking arbitrary decisions on this matter.

67. The Deprivation of Liberty Safeguards apply when the care or treatment of an individual without capacity, residing in hospital or a care home, can only be delivered in circumstances which represent more than restriction of their liberty but instead amounts to a deprivation of their liberty.
DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) and the Judgment of the Supreme Court

68. P v Cheshire West and Chester Council and another P and Q v Surrey County Council

69. The above ruling resulted in changes to how DoLs are assessed and authorised

70. The following question should be asked:

1) Is the person objectively deprived of their liberty or is there a risk that cannot be sensibly ignored that they are objectively deprived of their liberty?

71. There are two key questions to ask – the ‘acid test’:

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

All of these factors are necessary. You should seek legal advice if intensive levels of support are being provided to any person as part of a package of care or treatment.

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.

NB: 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.

72. In all cases, the following are not relevant to the application of the test:

1) The person’s compliance or lack of objection;
2) The relative normality of the placement (whatever the comparison made); and
3) The reason or purpose behind a particular placement.

73. This document is based upon the law as it stands as at March 2014; it is intended as a guide to good practice, and is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon this document.
74. DOLS regime cannot be used for a child under 18;

75. A DOLS authorisation cannot be used to authorise a deprivation of liberty taking place in a children's home;

76. The Court of Protection can authorise the deprivation of a person’s liberty from the age of 16.

77. The DOLS process for obtaining a standard authorisation or urgent authorisation can be used where individuals lacking capacity are deprived of their liberty in a hospital or care home.

78. The Court of Protection can also make an order authorising a deprivation of liberty.

79. This is the only route available for authorising deprivation of liberty in domestic settings such as the adult’s own home and supported living arrangements.

80. For Further information please see The Law Society web site – Deprivation of Liberty: a practical guide 9th April 2015

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Who Deprivation of Liberty Safeguards Applies to

81. Deprivation of Liberty safeguards protect people who are 18 years and over who lack capacity to make decisions about treatment or care and who need after all other avenues have been explored to be cared for in a restrictive way. For example, some people who have dementia, a mental health problem (not detained under the Mental Health Act 2007) or a significant learning disability. The aim of the safeguards is to:

- 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
- Provide safeguards for adults at risk
- Provide the rights to challenge unlawful detention against the person's will.

82. Where the Deprivation of Liberty Safeguards is applied in a hospital setting, the supervisory body is the Local authority, who since April 1st 2013 became the only Supervisory Body for the Deprivation of Liberty outside the Court of Protection. Hospitals will be required apply to local authority Supervisory
Bodies where they think they may need to deprive a patient of their liberty to treat them.

83. Applications can be made on either an ‘urgent’ or ‘standard’ basis.

84. An urgent application involves the managing authority (hospital or care home) actually granting itself an authorisation to deprive an individual of their liberty for a period of 7 days whilst the supervisory body considers the application. This period can be extended for a period of 7 days in exceptional circumstances.

85. A standard authorisation can be applied for up to 28 days in advance of when the managing authority wishes to plan to deprive the person of their liberty. Examples of this practice are around planned acute hospital admissions which require specific restrictions to be in place and which have been agreed following the MCA process.

86. Authorisation forms for urgent or standard DoLs can be downloaded from the Warrington Council website

87. Hospitals remain responsible as managing authorities, for compliance with the DOLS legislation, for understanding the DOLS and knowing when and how to make referrals. Hospitals also remain responsible for ensuring that all care and treatment in hospitals is Mental Capacity Act (MCA) compliant.

88. Those staff employed by the WCCG 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 and how the organisation is managing DoL processes.

89. If you are visiting a care home or hospital where you think a person is being deprived of their liberty, you should see if care could be provided in a less restrictive way. If depriving the person of their liberty seems unavoidable, you should advice that an application should be made for a standard authorisation at the same time as an urgent authorisation is given.

90. If someone in another setting is possibly being deprived of their liberty you should bring this to the attention of the manager so they either change their care or seek authorisation. Other options are to inform the supervisory body, to make a safeguarding alert to the local authority, or to challenge what may be an unlawful deprivation of liberty in the Court of Protection.

91. WCCG employees and Practice Member Clinical leads should report any concerns of none compliance with the MCA/DoLs back through their organisations governance structures.
92. This policy therefore does not seek to give detailed guidance on the matter, but instead signposts staff to the DoLS code of practice, to the literature produced by the Department of Health, and to the body of decisions made by the court of protection. Staff are advised to refer to the Policy for MCA/DoLS which sits with Warrington Borough Council.

For further information employees should refer to the DoLS Code of Practice. The relevant authorisation forms can be found and downloaded via the Warrington Council web site.

Consultation Process

93. This policy will be shared and consultation shall be sought via key agencies and partners in particular The Local Authority MCA/Dols Lead and GP Practice members.

Dissemination and Implementation

94. This policy upon ratification via the Quality Committee Members will be made available on the trust intranet site.

95. Following approval this document will be entered onto the corporate document database.

96. 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.

Monitoring Compliance and Effectiveness

97. Compliance towards this policy will be achieved by the monitoring of providers using:

- Safeguarding self-assessment audit tool.
- Quarterly dashboard completion
- Monitoring visits
  
  The aforementioned will be standing agenda items on the contract quality meeting agenda.

98. Please refer to the overarching commissioning safeguarding adults and children’s policy for relevant appendices relating to auditing requirements.
99. WCCG will be required to continue to have yearly mandatory e learning training which encompasses safeguarding adults and children and MCA/DoLS

100. This policy will be reviewed and monitored by Warrington CCG Safeguarding leads on an annual basis or sooner dependent on any changes to legislation.

References


Church.M, Watts. S. Assessment of Mental Capacity: a flow chart guide (on line) Royal College of Psychiatrists (17/05/13).
http://pb.rcpsych.org/content/13/8/304/f1.expansion.html


NHS England (2013) an Aide Memoire for Clinical Commissioning Groups: Safeguarding Adults


The Law Society – Deprivation of Liberty; a practical guide 2015

Appendix

1. MCA Assessment / Best Interest Tool
2. CHC Consent form
3. MCA Flow Chart
Appendix 1 - Mental Capacity Assessment

For use by WCCG employees and Practice staff. To be completed by the person proposing the treatment

Patients Name

DoB

NHS Number

Date of assessment

What is the decision to be made/issue (This must always be time and decision specific)

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Is there are least restrictive option?

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Can the decision wait?

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The starting assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity.

In order to decide whether an individual has the capacity to make a particular decision they must answer two questions:
Consider when assessing capacity used of resources, easy read, booklets, and if required access to professionals such as SALT

Assessment questions

Q1

Stage 1: Is there an impairment of, or disturbance in the functioning of a person's mind or brain? Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)  Yes/No

If Yes to question one then proceed to Q2

If No the person is deemed to have capacity

Q2

Functional test

Stage 2:
A) With help is the person able to understand the relevant information - the decision, consequences

Yes / No

Evidence
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B) Can they retain the information

Yes No

Evidence
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C) Can they weigh up the information?

Yes No

Evidence
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D ) Can they communicate the decision back

Yes No

Evidence…………………………………………………………………………………………………………………………
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…………………………………………………………………………………………………………………………………………

If the answer to any of Q 2 (A to D) is NO then the person lacks capacity

When making the assessment of capacity the assessor should ensure that:

- All relevant and sufficient information has been given by the most effective method of Communication- consider advocates, input from SALT etc
- Best location has been chosen where the person feels most at ease to make the decision
- The best time of day has been chosen to make the decision
- If the person would benefit from having another person present the arrangements have been made
- Consider if the impairment of capacity is temporary and if so can the decision wait?
- Remember people are allowed to make unwise decisions
Evidence and Conclusion / Outcome

Decision-maker: ..................................................................................................................

Organisation: ......................................................................................................................

GP Practice: ....................................................................................................................... 

Role: ..................................................................................................................................

Telephone Number: ..............................................................................................................

Signature: ............................................................................................................................

Date assessment completed: ............................................................................................... 

Counter signature: ..............................................................................................................

Please refer to the best interest checklist and the need for a MDT meeting when considering if the decision to be made is in the persons best interest.
Best Interest Meeting

Mental Capacity Act (2005)

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/her best interests-Principle 4 of the MCA

<table>
<thead>
<tr>
<th>Meeting held on:</th>
<th>Venue:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Male / Female   Ethnicity</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
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</table>

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<thead>
<tr>
<th>Chair of meeting</th>
<th>Decision Maker</th>
<th>Minute Taker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of participants</td>
<td>Designation / Location</td>
<td>invited</td>
</tr>
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</table>
Confirmation of ‘lack of capacity’

Mental Capacity Record assessment attached and completed

AND

Those present / invited agree that the person ‘lacks capacity’ to make the decision (In the event of anybody challenging the assessment result, and the disagreement cannot be resolved, then a second opinion or a ruling from the Court of Protection may be required. This will depend on the urgency of the decision to be made)

Comments:

Regaining of Capacity (Is it likely that the person may regain capacity, can the decision wait until that time, if not why not?)

Is this the least restrictive option? (If not, why not?)
Justification for proposed care / treatment:

Risks relating to proposed care / treatment:

Risks related to not carrying out the proposed care / treatment:

What are the persons past and present wishes and feeling (These may have been expressed verbally, in writing or through behaviour or habits)
Are there any beliefs and or values that would be likely to influence the decision, if he/she had the capacity? (e.g. religious, cultural, moral or political)

What are the views of the other relevant people in the person’s life?
What are the views of the Mental Capacity Advocate (IMCA)? (If involved)

Are there any advanced decisions? Yes /No

Does anyone hold lasting powers of attorney? Yes/No

Is there a dispute about best interests?
Outcome of discussions; reasonable belief as to best interests-

Where the court is not involved, carers (unpaid), relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances.
The undersigned believe this to be a fair and accurate representation of the discussions that took place. Those in attendance have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

<table>
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<td>Designation:</td>
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</table>
Appendix 2 - Consent to Screening and Assessment for NHS Continuing Healthcare / Funded Nursing Care

<table>
<thead>
<tr>
<th>Patients name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td>NHS No:</td>
</tr>
<tr>
<td>Current Residence:</td>
<td></td>
</tr>
</tbody>
</table>

Under the terms of the 2005 Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity.

1A) Person has capacity - If a person has capacity, only they can consent:

I have received verbal / written information on the Continuing Healthcare assessment process and I am aware that I can withdraw consent at any time.

Date consent withdrawn:

I have been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy, and that I have the right to decline any subsequent offer of care.

I consent to an NHS Continuing Healthcare Checklist / Fast Track / Decision Support Tool and any subsequent reviews being undertaken.

I consent to relevant information being gathered, collated and shared, where necessary and relevant, both as part of the PCT NHS Continuing Care process and as part of any subsequent dispute, including Independent Review Panel and Parliamentary and Health Service Ombudsman (PHSO).

I would like the following person / representative involved in the assessment:

Name:

Relationship:

Contact Number:

Signature of Patient:    Date:

Print Name:

1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:

Signature:    Name:    Designation / relationship:    Date:

Issue Date: May 2015    Page 33 of 42    Document Name: Mental Capacity Act and Deprivation of Liberty Safeguards Policy    Version No: 2

Author: Julie Ryder    Lead Director: Dr A Davies
1C) Person has capacity - Consent to share and protect your personal information

I agree that the information provided in this assessment may be shared with health and social care staff, service providers who contribute to or provide my care and any agencies acting on behalf of these organisations for the purpose / process relating to Continuing NHS Healthcare.

I understand that this information will be used in the assessment of my eligibility for NHS continuing healthcare funding and may be used for the purpose of providing a service, or care to me.

I understand that I may withdraw my consent to share information at any time.

I understand that I have the right to restrict what information may be shared and with whom but that this may affect the provision of care to me.

I have made the following restrictions (if applicable):

I understand that my information will be held on paper and on computer in accordance with the Data Protection Act 1998.

Signature: ____________________________ Date: __________

Print Name: __________________________ Date: __________

1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:

Signature: __________________________ Name: __________________________ Designation / relationship: __________________________ Date: __________

Signature: __________________________ Name: __________________________ Designation / relationship: __________________________ Date: __________

If the person does not have the capacity to consent then a ‘Best Interest’ decision will need to be made. Please proceed to complete the Best Interest part of the form.
2) **Best Interest Consent to Screening and Assessment for NHS Continuing Healthcare / Funded Nursing Care for People who lack capacity**

<table>
<thead>
<tr>
<th>Name of Patient:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td>Current Residence:</td>
</tr>
<tr>
<td></td>
<td>NHS No:</td>
</tr>
</tbody>
</table>

**Under the terms of the 2005 Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity.**

### 2A) Best Interests Checklist

<table>
<thead>
<tr>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I have made every possible attempt to permit / encourage the person to take part in the assessment process</td>
<td></td>
</tr>
<tr>
<td>I have tried to identify all the things that the person would take into account if they were making the decision or acting for themselves.</td>
<td></td>
</tr>
<tr>
<td>I have tried to find out the views of the person who lacks capacity, including past / present wishes and feelings, any beliefs and values and any other factors that the person themselves would be likely to consider if they were making the decision or acting for themselves.</td>
<td></td>
</tr>
<tr>
<td>I confirm that I have not made assumptions about their best interests on the basis of the person's age, appearance, condition or behaviour.</td>
<td></td>
</tr>
</tbody>
</table>
| I have considered whether the person is likely to regain capacity.  
  - If yes, can the decision wait until then?  
  - If no is the person likely to regain capacity?  
  - If yes, can the decision wait until then?  
  - If no continue with the Best Interest Assessment | |

*If it is practical and appropriate to do so, consult other people for their views about the person’s best interests. This may include:*
  - Any individual appointed under a lasting power of attorney
  - Any deputy appointed by the Court of Protection
  - Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues
  - Anyone engaged in caring for the person
  - Close relatives, friends or others who take an interest in the person’s welfare
  - An Independent Mental Capacity Advocate (IMCA)
Where the patient has nobody to act for them, other than paid carers, and a decision concerns serious medical treatment or a change in living arrangements (NHS accommodation for 28 days or more or Local Authority / Care Home accommodation for 8 weeks or more) then a referral must be made to an IMCA.

<table>
<thead>
<tr>
<th>Date of referral:</th>
<th>Made by:</th>
</tr>
</thead>
</table>

### 2B) Other people Consulted (where applicable)

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Taking all of the above information into account, I confirm that proceeding with the assessment process is in the best interests of:

Name of patient:

**OR**

I am the attorney appointed under a Lasting Power of Attorney - **Welfare** made by the person / deputy appointed by the Court of Protection and agree on the patient’s behalf. **A copy of the LPA or Court of Protection must be provided with this form.**

**NB: Lasting Power of Attorney (LPA) must have the power / scope to act in the circumstances and the LPA must be registered with the Office of the Public Guardian**

I have received written information on both the Continuing Healthcare Process.

I have been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy and that I have the right to decline any subsequent offer of care.

I **confirm** that it is in the best interests of (patients name)…………………………. to an NHS Continuing Healthcare Checklist / Fast Track/Decision Support Tool and all subsequent reviews being undertaken.

I **confirm** that it is in the best interests of (patients name)………………………….for relevant information to be collated and shared, where necessary both as part of the PCT NHS continuing healthcare assessment process, any subsequent care provision and also as part of any dispute process which may occur. This could include the PCT and Strategic Health Authority Independent Review Panel (IRP) or Parliamentary and Health Service Ombudsman (PHSO).
Appendix 3 – MCA Flow Chart

Impairment/disturbance in functioning of mind/brain

Yes

Doubts raised about capacity to make particular decisions

No

Yes

Identify and clarify decisions to be made

Properly supported process enables person to make decisions in question

Yes

No

Decide what evidence is necessary for a proper test

Gather and document evidence

Make a decision-specific test (with supported process as necessary

Decide and document basis for decision

Repeat test as necessary

Take action on basis of outcome of test of capacity

Person has capacity (assumption of capacity)

With thanks to the Royal college of Psychiatrists
## Appendix 4 – GP system Record of Capacity Assessment under the Mental Capacity Act

Name of Person being assessed: .................................................................

Date of Birth ............................... NHS Number .................................

Put a cross in boxes * if extra information and record on the supplementary sheet

<table>
<thead>
<tr>
<th>Assessment Question</th>
<th>Tick your assessment</th>
<th>Tick your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Is there an impairment or disturbance in the functioning of mind or brain? (Permanent or temporary).</td>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
<tr>
<td></td>
<td>Impairment is present, record symptoms/behaviours, any relevant diagnosis. ☐*</td>
<td>Impairment is not present, record evidence... If NO the person is deemed capable - assessment is complete ☐*</td>
</tr>
<tr>
<td>3. If yes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) With all possible help given is the person able to understand (U) the information relevant to the decision? Avoid questions inviting yes or no answers. Try “What do you think this decision means? How will this decision affect you? Why do you think this decision needs to be made?”</td>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
<tr>
<td></td>
<td>Able to understand info. Record views/evidence to show they understood it. ☐*</td>
<td>Unable to understand info. Record steps taken to explain info and views/evidence why they did not understand it. ☐*</td>
</tr>
<tr>
<td>b) Are they able to retain (R) the information long enough to make the decision? e.g. “Tell me what you understand by …?”</td>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
<tr>
<td></td>
<td>Able to retain information, record evidence. ☐*</td>
<td>Unable to retain information, record any evidence. ☐*</td>
</tr>
</tbody>
</table>
Remember they only need to retain long enough for you to be sure they have understood.

c) Are they able to balance (b) or weigh the information as part of the decision making process?

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to weigh information, record evidence.</td>
<td>Unable to weigh information, record evidence.</td>
</tr>
<tr>
<td>☐*</td>
<td>☐*</td>
</tr>
</tbody>
</table>

d) Are they able to communicate (c) the decision

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to communicate, record evidence.</td>
<td>Unable to communicate, record evidence.</td>
</tr>
<tr>
<td>☐*</td>
<td>☐*</td>
</tr>
</tbody>
</table>

**Conclusion** - If the answer to 2. Is **YES** Please code as XaXvXr and the answer to any of 3. a) - d) is **NO** then the person lacks capacity under the Mental Capacity Act 2005.

Fluctuating Capacity: Always consider whether the person has fluctuating capacity and whether the decision can wait until capacity returns. If this is the case, explain and enter reassessment date in outcome below.

<table>
<thead>
<tr>
<th>Name, Role and Signatures of Assessor (s)</th>
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</table>

<table>
<thead>
<tr>
<th>Date (DD/MM/YYYY)</th>
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**Outcome:**

<table>
<thead>
<tr>
<th>Name, Role and Signatures of Assessor (s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date (DD/MM/YYYY)</th>
</tr>
</thead>
</table>
**Best Interests – Reaching a Decision**

Name of Person being assessed: ........................................................................................................

Date of Birth: .............................................. NHS Number .................................................................

**NB. Ensure you do not make assumptions about what is in a person’s best interests based on their age, appearance, condition or behaviour. (Principle of equal consideration)**

Ensure that wherever possible a less restrictive option is chosen, whilst still representing best interests.

<table>
<thead>
<tr>
<th>Specify the different options that are being considered</th>
<th>Is this in the best persons interest Yes/No</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

If your final decision is at odds with anybody who was consulted please highlight the reasons for your decision. Consider application to the Court of protection if there is dispute.
Decision maker (s) : Name ........................................ Signature: ........................................
Role .................................................................
Organisation ......................................................

Decision maker (s) : Name ............................. Signature: ........................................
Role .................................................................
Organisation ......................................................

Date: .......................... (DD/MM/YYYY)