Sussex and East Surrey Commissioners

NHS

Sussex and East Surrey Sustainability and Transformation Partnership (STP)

Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Guidance for staff

APPROVED BY:	**Approved by Quality and Governance Committee September 2018**
EFFECTIVE FROM:	**September 2018**
REVIEW DATE:	**September 2020**

This policy must be read in conjunction with the following policies:

Adult and Child Safeguarding Policy

Version Control

Policy Category:	Quality and Safety	
Relevant to:	All Staff (including temporary staff, contractors and seconded staff)	
Version History		
Version No.	Date	Changes Made:
0.1	May 2016	Initial version drafted by Designated Nurse Safeguarding Adults
0.2	August 2016	Review by Governance and Policy Officer
0.3	August 2016	Review by Chief Nurse
0.4	August 2016	Review by Chief Operating Officer
1.	21/09/2016	Approved by Quality and Governance Committee
1.1.	July 2018	Review by Governance and Policy Officer
1.2.	September 2018	Review by Designated Nurse Safeguarding Adults to create an STP-wide policy
1.3.	October 2018	Review by Chief Nurse
1.4.	November 2018	Review by Managing Director
2.	21/11/2018	Approved by Quality and Governance Committee

The MCA has been subject to Equality and Diversity Impact Assessment nationally by the Department of Justice. Equality and diversity is therefore implicit within the policy.

Contents

1. INTRODUCTION.

1.1 The Mental Capacity Act 2005 (MCA) provides a legal framework to provide protection for people who cannot make decisions for themselves. The underlying philosophy of the MCA is to ensure that individuals who lack capacity, and are of 16 years of age or more, are the focus of any decisions being made about them.

1.2 MCA consolidates human rights law for people who may lack capacity to make their own decisions. It promotes the empowerment of individuals and the protection of their rights.

1.3 Everyone working with, or caring for, an adult who may lack capacity to make a specific decision **must** comply with MCA, whether that decision relates to a life-changing event or an everyday matter, and that decision must be in the person's **best interests**.

1.4 Various pieces of legislation are relevant to this policy which employees should be familiar with and refer to as necessary:

- The Care Act 2014.
- Mental Capacity Act 2005.
- The Mental Capacity Act Code of Practice.
- Deprivation of Liberty (DoLS) Code of Practice.
- Cheshire West Supreme Court Judgement.
- Human Rights Act 1998.
- European Convention on Human Rights.

See **Appendix 3** for more details. This list is not exhaustive.

2. PURPOSE AND SCOPE.

2.1 It has been made clear through the NHS Safeguarding Vulnerable People - Assurance and Accountability Framework 2015 that NHS England expects all service providers that are funded by the NHS to meet the legal requirements of MCA, and that commissioners are required to ensure the services they commission are complying with MCA.

2.2 This policy details the roles and responsibilities of the East Surrey and Sussex CCGs, known as the STP for the purpose of this document, as commissioning organisations, with respect to MCA. It is applicable to employees, in particular those working in Continuing Healthcare (CHC), who have responsibility for commissioning NHS Continuing Healthcare and NHS Funded Nursing Care (FNC). This policy can also be adopted by member practices of the CCGs.

2.3 The STP will:

- Ensure MCA is given high profile within its internal structures.
- Appoint an MCA Lead.
- Ensure they commission MCA compliant care and ensure that providers meet their statutory responsibilities.

- Ensure staff employed by the CCGs are aware of their responsibilities under the MCA and the accompanying Code of Practice (DH) and receive training commensurate to their role and responsibilities.

2.4 This policy aims to ensure that no act or omission by STP as a commissioning organisation puts an adult who may lack capacity at risk, and that robust systems are in place to promote the rights of adults without capacity in services that CCG residents may access.

3. ROLES AND RESPONSIBILITIES.

3.1 The East Sussex STP is committed to ensuring that health provision fulfils its roles, as set out in the Sussex Safeguarding Adults Policy and Procedures and the Surrey Adult Safeguarding Policy and Procedures and has in place accountability and reporting framework to provide assurance that their duties are being fulfilled to benefit residents.

3.2 Accountable Officer (AO) – Sussex CCGs Accountable Officers (Chief Officer) has responsibility for ensuring that the health service contribution to upholding the principles of the MCA is discharged effectively across the whole health economy. This is operationally delivered through local commissioning arrangements.

3.3 Executive Lead for Safeguarding - The Executive Lead is the STP Chief Nurse who ensures the monitoring of commissioned services for compliance with the MCA

3.4 All Executive Directors and Lay Members - Directors are responsible upholding the principles of the MCA and maintaining focused leadership for those least able to advocate for themselves and ensuring that their needs are at the forefront of local planning and service delivery

3.5 Designated Nurse Adult Safeguarding.

The Designated Nurse Adult Safeguarding is also the named MCA/DoLs lead for the individual CCGs of the STP and they will have responsibility for:

- Ensuring staff and member practices are aware of and comply with MCA/DoLs and accompanying Codes of Practice.
- Ensuring MCA/DoLS training is offered to CCG staff commensurate to their roles and responsibilities.
- Engaging with Local Authority, Provider Safeguarding Leads and Care Quality Commission (CQC) to ensure consistent leadership on MCA/DoLs across the health economy.
- Keeping up to date with implementation of MCA and any changes in legislation and case law updates including Court of Protection decisions and government response such as House of Lords Select Committee's post legislative scrutiny (2014).
- Seeking assurance from providers that they are working in accordance with and the ethos of MCA/DoLs legislation.

The above list is not exhaustive.

3.2 Continuing Healthcare (CHC) Team.
CHC employees of the CCGs have direct patient contact and are responsible for:

- Attending MCA/DoLs training.
- Ensuring they have a working knowledge of the principles and practice of the MCA and that they are applied to all those in receipt of CHC funding.
- Promoting the use of advance decisions and Lasting Power of attorney (LPA) when appropriate.
- Contributing to best interest meetings when requested to do so.
- Completing or ensuring Capacity Assessments are completed when assessing or reviewing patients for CHC funding.
- Act as Best Interest Decision Maker when appropriate to do so.
- Refer patient to an advocacy service when appropriate to do so.
- Raising safeguarding concerns to the Local Authority if they suspect abuse or neglect.
- Ensuring applications are made to the appropriate bodies where it is thought that a person in receipt of CHC is being deprived of their liberty.

3.3 Quality Team Procurement, Contract Monitoring, Service Delivery and Redesign Teams.

- These teams will need to ensure that MCA/DoLs is given due regard in all service plans, specifications, contracts and invitations to tender and the standard of evidence to demonstrate compliance.
- Ensure they have consulted with the named MCA/DoLs Lead.
- Quality Team will need to seek assurance from providers that the MCA and DoLs provision is given due regard and they are working within the ethos of the MCA.

3.4 CCG employees and those of GP member practices **must** report any concerns of non-compliance with MCA/DoLS via line management safeguarding reporting systems

3.5 The Designated Nurse Safeguarding Adults (MCA Lead) may be contacted for advice and information. See the Key Staff Contact details on the Intranet for full details.

4. STATUTORY PRINCIPLES OF MENTAL CAPACITY ACT.

4.1 MCA 2005 defines lack of capacity in the following way:

> *"a person lacks capacity in relation to a matter if, at the material time, he/she is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning, of the mind or brain."*

4.2 Capacity is decision specific and relates to the ability to make a particular decision at a particular time. It is not a blanket judgement about an individual's ability to make decisions in general. MCA applies to people who are 16 years or older.

4.3 A person may have capacity to make a decision about what to eat or wear but not relating to financial matters or where to live. There are five statutory principles of the MCA which must underpin all decisions taken in relation to the act:

- Every adult has the **right to make their own decisions** and it must be assumed they have capacity to do so unless it is proved otherwise.
- A person must be given **all practicable help** before anyone treats them as not being able to make their own decision.
- Making what may appear to be an **unwise decision** does not mean the person is lacking capacity.
- Any decisions made on behalf of a person who lacks capacity must be done in their **best interests**.
- Anything done on behalf of a person who lacks capacity must be the **less restrictive** option.

4.4 There is a two-stage Capacity Assessment (see **Appendix 1**) which should be used when determining if a person may lack capacity under the definition provided by MCA Capacity Assessment.

4.5 Stage 1 Diagnostic Test:

- Does the person have an impairment of the mind or brain, or is there some disturbance which may affect the way their mind or brain works?
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

4.6 If the Diagnostic Test indicates capacity may be affected then a Stage 2 Functional Test is undertaken to assess the person's ability to make a decision for themselves.

4.7 Stage 2 Functional Test.
It is likely that a person will be unable to make a decision if they cannot:

- Understand the information about the decision made.
- Retain the information.
- Use / weigh up that information as part of a decision-making process.
- Communicate their decision by any means possible.

4.8 Best Interest Decisions. (See **Appendix 2**).
Decisions or actions made on behalf of someone else must:

- Consider whether the person is likely to regain the capacity to make the decision in the future and can the decision be delayed until such time.
- Consider if the decision made is the less restrictive option.
- Have objective reasons for the decision made or action taken.

4.9 The person making a decision, or acting on behalf of a person who lacks capacity, is known as the **best interest decision maker** and should be able to demonstrate clearly the steps they have taken to assess capacity and to ensure the decision made is the person's' best interest.

4.10 An assessment of mental capacity for important decisions such as medical treatment, moving home, financial decisions or a Do Not Attempt Resuscitation (DNAR) form should be completed following the Best Interest Flowchart. Routine day-to-day decisions such as what to eat or what to wear will not require such in- depth documentation.

5. LASTING POWER OF ATTORNEY (LPA).

5.1 People can give statutory authority, whilst they still have capacity, for other people to make decisions on their behalf once they have lost capacity to do so for themselves.

5.2 There are two types of LPA:

- Health and Welfare.
- Property and Finance.

5.3 A Lasting Power of Attorney agreement must be registered with the Office of the Public Guardian before it is valid.

6. ADVANCE DECISIONS.

6.1 An advance 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.

6.2 An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity. Healthcare professionals must follow the decision.

6.3 People can only make an advance decision under MCA if they are aged 18 or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision at any time.

6.4 More information can be found in Chapter 9 of the MCA Code of Practice at: www.gov.uk/government/publications/mental-capacity-act-code-of-practice

7. INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA).

7.1 MCA introduced the role of an IMCA. They are a legal safeguard for people who lack capacity to make important decisions such as where to live or decisions about serious medical treatment.

7.2 The IMCA role is to ensure that the MCA is being followed, and to support and represent the views of the person at the heart of the decision.

7.3 IMCAs are usually instructed to represent a person when there is no family or friend, independent of services, to represent them.

7.4 MCA set out the IMCA's roles and functions. These are grouped into four areas:

- Gathering information.
- Evaluating Information.
- Making representation.
- Challenging decisions.

7.5 Pohwer provide advocacy services in East Sussex including IMCA and can be contacted on www.pohwer.net/east-sussex.html or 0300 456 2370.

8. DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS).

8.1 DoLS were created to support people who lack capacity to consent to treatment or care that might deprive them of their liberty where this treatment is in their best interest, or will protect them from harm.

8.2 There is a legal process for this deprivation which makes sure that it is in the person's best interest and there is no other less restrictive option.

8.3 DoLS is **an addition to** MCA legislation.

8.4 DoLS only applies to people over 18 years of age and who are **NOT** detained by the Mental Health Act 1983 (MHA).

8.5 The Supreme Court laid down an "Acid Test" in March 2014 to assist care providers and assessors to identify a Deprivation of Liberty, it states a person is deprived of their liberty if:

> *"The person is under continuous supervision and not free to leave and they lack capacity to consent to these arrangements regardless of their compliance or lack of objection."*

8.6 Deprivation of Liberty can occur in a care home, hospital or domestic setting such as supported living. Within a care home or hospital setting the supervisory body is the Local Authority (LA). LAs are now the only supervisory bodies for Deprivation of Liberty outside the Court of Protection.

8.7 Hospitals or Care Homes must apply to the Local Authority Supervisory Bodies where they think a person may need to be deprived of their liberty in order to treat them.

8.8 DoLS application must be made to the Court of Protection for authorisation if the Deprivation of Liberty is within a domestic setting or the person's own home.

9. COURT OF PROTECTION.

9.1 The Court of Protection has jurisdiction relating to the whole of the MCA and is the final arbiter for capacity matters. It has its own procedures and nominated judges. In cases where there are particular concerns or an agreement cannot be reached relating to capacity or best interests, the Court of Protection can be consulted to make a judgement.

9.2 The issues that may be referred to the Court are serious complex matters which, after considering all options available, remain irresolvable. The Court should be seen as a provision of last resort. The Court can make a decision where there is a single issue, or appoint a Deputy where there are a series of ongoing decisions to be made.

9.3 Court Appointed Deputies.
Where the Court believes that there is likely to be a need for ongoing decision-making powers on behalf of a person lacking capacity, it may appoint a Deputy to act for, and make, such decisions on behalf of the person.

10. THE PUBLIC GUARDIAN.

10.1 The Public Guardian and its staff are the registering authority of LPAs and deputies.

10.2 They supervise deputies appointed by the Court of Protection and provide information to the Court to help make decisions.

10.3 They also work together with other agencies such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

10.4 The Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges their duties.

11. WILFUL NEGLECT.

11.1 MCA created a new criminal offence of wilful neglect or ill treatment of a person who lacks capacity. This is punishable by a fine or a sentence of up to five years imprisonment or both.

11.2 These offences may apply to anyone caring for a person who lacks capacity. This includes family members, carers, health or social care staff in hospital, care homes and those providing care or support in a person's home.

11.3 Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must:

either

- have deliberately ill- treated the person;

or

- been reckless in the way they treated the person.

11.4 It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

11.5 The meaning of wilful neglect varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act they knew they had a duty to do.

11.6 Where ill treatment or wilful neglect is suspected, the police must be informed and the Safeguarding Adults Procedure should be instigated.

11.7 For further information please see the Law Society website article on Deprivation of Liberty: www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

12. EQUALITY.

In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

13. MONITORING AND REVIEW.

13.1 The policy and procedure will be reviewed every two years. Where review is necessary due to legislative change, this will happen immediately.

13.2 An Equality Analysis Initial Assessment has been carried out on this policy. As a result, there is no anticipated detrimental impact on any equality group.

Appendix 1: Two Stage Capacity Assessment.

Two Stage Capacity Assessment			
Patient name:			
Date of birth:			
NHS no:			
Name of practice:			
Name of person completing assessment:			
Date completed:			
Signature of person completing assessment:			
What triggered the capacity assessment?			
Stage 1: Diagnostic Test			
Q1. Does the person have an impairment of, or disturbance in the functioning of, the mind or brain?		**Yes**	**No**
If the answer is **'no'** then the person **cannot** lack capacity within the meaning of the MCA. Please make a note in the patient record. If the answer is **'yes'** please answer **all** the following questions.			
Clinical diagnosis: Where the impairment or disturbance arises out of a specific diagnosis, please set out the diagnosis or diagnoses here.			

What is the decision that needs to be made?		
Is this impairment or disturbance:	**Fluctuating**	**Permanent**
Q2. If the person has fluctuating capacity does the decision need to be made immediately?	**Yes**	**No**
Please explain why:		
Stage 2: Functional test		
Q1. Does the person have a general understanding of the decision they need to make, why they need to make it and the likely consequences of making the decision (including the consequences of making no decision at all)?	**Yes**	**No**
Please give details:		
Q2. Is the person able to retain information relevant to the decision long enough to take it?	**Yes**	**No**
Please give details:		

Q3. Is the person able to use or weigh information relevant to the decision, as part of the process of making the decision?	**Yes**	**No**
Please give details:		
Q4. Is the person able to communicate their decision (by talking, using sign language, or any means at all)?	**Yes**	**No**
Please give details:		
If the answer to any of these questions is **'no'**, and this is caused by the impairment or disturbance you have identified, and your decision is on a balance of probabilities, the person **lacks capacity to make this decision**.		

Advance Decisions		
Has the person made a health and welfare **Lasting Power of Attorney** which has been registered and gives the attorney(s) the authority to make the decision in question?	**Yes**	**No**
Has the person made a valid, applicable **advance decision to refuse the same treatment** that this decision is about?	**Yes**	**No**
Has a **deputy been appointed by the Court of Protection** with the power to make the decision in question?	**Yes**	**No**
If you have answered **'no'** to **all** of the above, you may proceed with a **Best Interests** decision.		

Appendix 2: Best Interests Decision.

Best interests decision			
Is an IMCA referral required? If there is no one to consult (other than paid staff) to support or represent the person, or to be consulted as part of the best interest decision process.			
Name of IMCA:	**Tel**:		
What are the options available as they relate to the decision in question? Please consider the positive and negative aspects of each option, and note which is **less restrictive** in terms of the person's rights and freedom of action.			
Option 1:			
Option 2:			
Option 3:			
Have you identified and taken into account the person's past and present wishes and preferences, beliefs and values (including their treatment preferences) whether written or verbal?		**Yes**	**No**
What were these views?			

Have you consulted and taken into account the views of other interested parties (family, carers, friends, advocate, deputy or attorney)?	**Yes**	**No**
If **yes**, who was consulted and what was their view. *(please use additional space if necessary)*		
Have the views of other professionals involved in the person's care been consulted.	**Yes**	**No**
Please give details:		
Which option have you decided is in the person's best interests, and why (please record the decision clearly here)?		

Please describe how your decision reflects the **less restrictive** principle?			
Was there disagreement in reaching this decision? If **yes**, please give details and describe what actions are being taken to seek resolution.			
Has every option been explored in communicating this decision to the person?		**Yes**	**No**
Date of decision:	**Date of review:**	**Date of amendment:**	
Have the practice records been updated?		**Yes**	**No**

Appendix 3: References.

The Care Act 2014.
www.gov.uk/government/publications/care-act-2014-part-1-factsheets

The Care Act 2014. Statutory Guidance
www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

Care Quality Commission.
www.cqc.org.uk/guidance-providers/all-services/mental-capacity-act-deprivation-liberty-safeguards

Cheshire West Supreme Court Judgement.
www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

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

European Convention on Human Rights.
www.echr.coe.int/Documents/Convention_ENG.pdf

House of Lords Select Committee on mental Capacity Act 2005.
www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

Human Rights Act 1998.
www.legislation.gov.uk/ukpga/1998/42/contents

Mental Capacity Act 2005.
www.legislation.gov.uk/ukpga/2005/9/contents
www.nhs.uk/conditions/social-care-and-support/mental-capacity/

Mental Capacity Act 2005. Making Decisions.
www.gov.uk/government/collections/mental-capacity-act-making-decisions

Mental Capacity Act 2005. Deprivation of Liberty Safeguards.
www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

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

NHS Safeguarding Vulnerable People Assurance and Accountability Framework.
www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

Valuing every voice, respecting every right. Making the case for the Mental Capacity Act.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/318730/cm8884-valuing-every-voice.pdf