NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Mental Capacity Act and Deprivation of Liberty Safeguards

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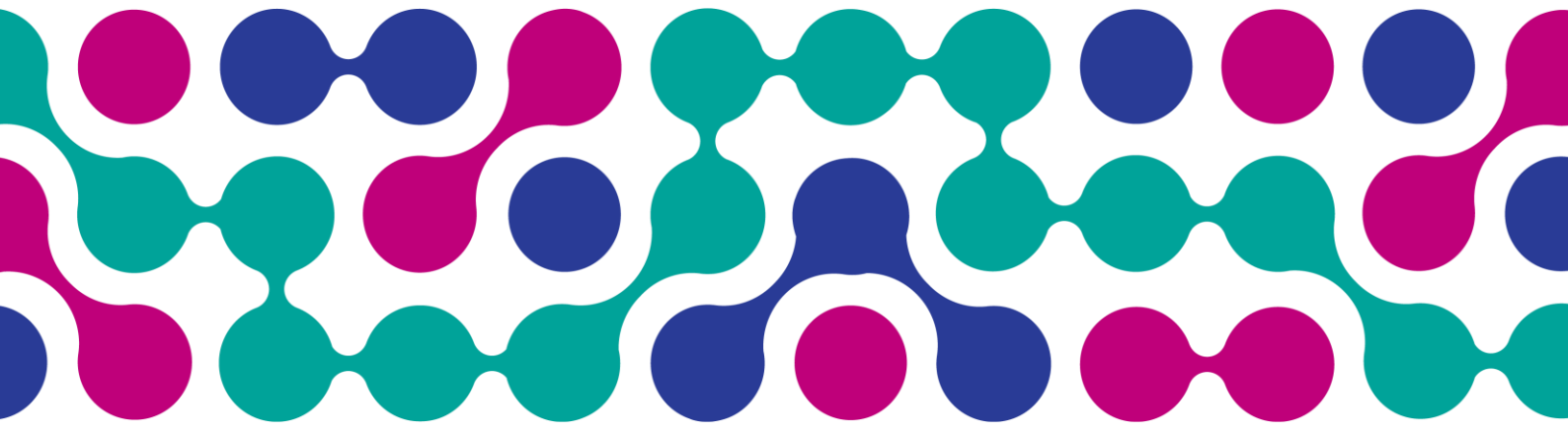

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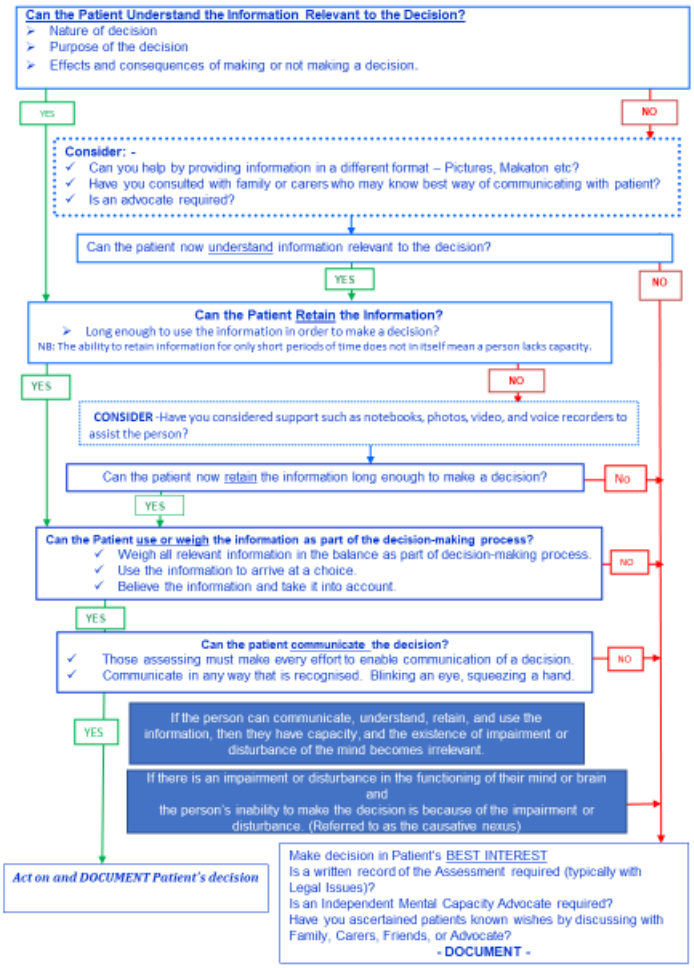
Document Manager:	Colette O'Neill	**Document Sponsor:**	James Dunne

Document summary	
Purpose:	The original policy was written for the Wiltshire Clinical Commissioning Group (CCG) in 2018. It was due for review in 2019 and so is out of date. Additionally, Bath and North East Somerset, Swindon, and Wiltshire CCG was formed in April 2020 and there is no overarching policy for this organisation. There is a need for one current policy to be available to BSW Integrated Care Board (ICB). The review of this policy provides a timely opportunity to draw colleagues attention to the changes anticipated from imminent implementation of the Mental Capacity (Amendment) Act 2019 and the introduction of a new process for authorising deprivations of liberty for persons who lack capacity to make decisions through the Liberty Protection Safeguards (LPS). One BSW ICB Policy will make it easier to implement any anticipated changes, and importantly, ensure we are currently compliant.
Key information:	Adherence to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards is mandatory whenever decisions are being made on behalf of people who lack capacity to make the decisions for themselves. The MCA (2005) and its Code of Practice as well as the DoLS Code of Practice have been superseded by case law. The Mental Capacity (Amendment) Act 2019 will be ratified by Parliament within the next 18 months and until this date, care should be taken to ensure specialist advice is taken if there are concerns about any interventions that might affect a person's Article 5 and Article 8 rights.
Specific colleagues/ teams:	All colleagues within BSW ICB.
Tables/ Flowcharts:	See below for flowchart and Appendix 1.

BSW Mental Capacity Assessment Flowchart



Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Contents

1. Introduction and purpose

This Policy relates to the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards 2009 as they currently stand in law. The aim is to support BSW ICB colleagues to understand and apply MCA and DoLS to their practice. It is needed because it is a statutory responsibility under the Human Rights Act (1998) for all BSW ICB colleagues to practice in a legally compliant way.

The Mental Capacity Act 2005 provides a statutory framework to protect and empower those people who lack the mental capacity to make decisions for themselves. The Act is supported by the Mental Capacity Act Code of Practice which Health and Social care staff have a legal duty to consider in all aspects of their practice. There is also a separate Deprivation of Liberty Safeguards Code of Practice (2008). This has largely been surpassed in case law and so as stand-alone guidance, needs to be supplemented by the additional guidance that has developed since in case law. Therefore, specialist advice should always be taken.

The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16th May 2019. It was due to come into force in April 2022, but has been delayed. It is likely that the change in the Law will now not happen until 2023. The Act amends the Mental Capacity Act 2005 and introduces a new process for authorising deprivations of liberty for persons who lack capacity to make a particular decision. These arrangements will be known as the Liberty Protection Safeguards (LPS). The two Codes that currently exist will be published as one integral guide to both the Mental Capacity (Amendment) Act and the Liberty Protection Safeguards. The new law and safeguarding arrangements will need to be underpinned by understanding of the existing Mental Capacity Act law and guidance. This policy has therefore been updated to ensure that colleagues are properly supported in preparation for the changes.

The Mental Capacity Act 2005 defines capacity and applies to everyone over the age of 16. It places the needs and wishes of a person unable to make their own decisions at the point where they need to do so at the centre of any decision-making process. It helps informal carers understand how and when they can and cannot make decisions on behalf of a family member who lacks capacity by identifying how, when and who can make decisions on behalf of another person. Through clearly identified processes for donating a lasting power of attorney or making an advanced decision, the Mental Capacity Act 2005 supports and enables people to plan ahead for a time when they may lose mental capacity. The Act introduced the role of the Independent Mental Capacity Advocate (IMCA) and the circumstances when Health and Social Care staff have a statutory obligation to instruct an Advocate. The Act also created an offence under section 44 - Wilful neglect or ill-treatment of a person who lacks capacity.

In accordance with the Mental Capacity Act 2005 there is a presumption of mental capacity unless an assessment of capacity shows otherwise. Capacitated adults are autonomous individuals who have the right to make their own decisions and choices including those which others, including professionals, may consider unwise.
The Act is underpinned by five statutory principles:

- **A presumption of capacity** – This is fundamental and should be the starting point to any conversation with a person facing decisions about their health and care needs. Every adult has the right to make his or her own decisions and must be assumed to have capacity unless it is proved otherwise.
  It is important to remember that **the person** does not have to 'prove' anything. The burden of proving a lack of capacity to take a specific decision always rests with the person who considers it necessary to take that decision on their behalf.
  The standard of proof that must be achieved is on the balance of probabilities.

- **Supported decision making** - The right for individuals to be supported to make their own decisions – all practicable steps have to be taken to ensure that the person has been given all appropriate help before anyone concludes that they cannot make their own decisions. Examples of practicable steps includes - having someone read written information, information given several times, having time to process information, use of simple words or visual representation, advice from a speech and language therapist may be needed or support from family, friends, advocate, being given information at the best time of day or in the most comfortable environment, being shown the available choices.

- **Unwise decisions** - Individuals have the right to make their own decisions including those which might be considered unwise.

- **Best interests** – anything done for or on behalf of people who lack capacity must be done in their best interests.

- **Least restrictive intervention** – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedom of action.

The Deprivation of Liberty Safeguards (DoLS) were incorporated into the Mental Capacity Act in 2009. They were intended to protect the article 8 rights of people who lack the capacity to make decisions and consent to arrangements made for their care and treatment when the arrangements constitute a deprivation of liberty.

The MCA is central to quality improvement, patient involvement and empowerment. BSW ICB have a duty to commission services which are delivered in a way that respects the rights of the individuals, in particular those

who are vulnerable because they may not be able to make decisions for themselves.

2. Scope and definitions

2.1 Scope

The policy applies to all BSW ICB colleagues, including those seconded into the organisation, volunteers, students, honorary appointees, trainees, contractors, and temporary workers. This list is not exhaustive.
The impact of the Mental Capacity Act 2005 (MCA) for BSW ICB is in relation to Commissioner's duties to ensure provider services are delivered in accordance with the MCA and that the rights of those who use those services are promoted and protected. BSW ICB has responsibility for commissioning high quality care and treatment. BSW ICB must ensure providers understand the MCA, apply it to practice and monitor compliance. Fundamentally BSW ICB needs to ensure that:

- The MCA is given a high profile and priority within BSW ICB
- There is compliance with the MCA and how this will be achieved is a key part of the tendering process
- On-going compliance is monitored in detail through performance review and quality monitoring processes

BSW ICB recognises its duty to commission services which are delivered in a way that respects the rights of the individuals, in particular those who are vulnerable and may not be able to make decisions for themselves. The MCA 2005 and DoLS 2009 will be considered in all aspects of the commissioning cycle; this will include service planning, procurement, monitoring and reviewing. The NHS Accountability and Assurance Framework 2019, together with Safeguarding & Mental Capacity Act schedules will be used for all contracts. The contract should prominently include both quality and safety measures in respect of The Mental Capacity Act 2005.

2.2 Definitions

Mental Capacity
Mental capacity is the ability to make a decision, with support, as necessary. These decisions can range from very simple issues such as deciding what clothes to wear, to highly significant life decisions (which may have legal and financial consequences) such as moving into long term residential care or whether to have a major operation.

What does it mean to lack capacity to make a decision?
This is a legal test and not a medical test. The specific definition is given in s.2(1) MCA 2005:

‘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 the brain.’

Assessing capacity

Capacity should be assessed whenever there is proper reason to doubt that the person is able to make the decision for themselves. An assessment is used to establish capacity and it should not be assumed that doing an assessment means that the person lacks capacity. At the same time, the act of assessing capacity can be an intrusion in itself and the decision to do an assessment must be based on having the grounds to do one.

A new draft MCA Code of Practice is currently open for consultation (March – July 2022). The existing Code has been supplemented by case law (A Local Authority v JB [2021] UKSC 52 at paragraph 79).

It is now advised that to assess capacity, there are 3 questions that should be asked, and these are best applied in the following order:

- Is the person able to make the decision (with support if required)? (Referred to as the functional test)
- If they are unable, is there an impairment or disturbance in the functioning of their mind or brain? (Referred to as the diagnostic test)
- Is the person’s inability to make the decision because of the impairment or disturbance? (Referred to as the causative nexus)

Inability to make a decision

In order to make a decision, the person must be able to:

- **C**ommunicate their decision
- **U**nderstand information relevant to the decision
- **R**etain that information long enough to be able to make the decision
- **B**alance - Use & Weigh up the information

The acronym ‘CURB’ may help with recalling the aspects that contribute to the decision-making process. Communicate only applies in situations where people cannot communicate their decision in *any way*. The other three should be applied together.

Understand information relevant to the decision

Before someone can make a decision, they must have been given all the ‘relevant’ information to help them make that decision and if necessary, in a way that helps them understand the information.

Relevant information includes:

- the nature of the decision,
- the reason why the decision is needed, and
- the likely effects of deciding one way or another, or making no decision at all.

It is important to ask questions to check that the person has understood the information. If a decision could have serious consequences, it is even more important that a person understands the information relevant to that decision.

The person should be able to give some form of explanation of the information that has been explained to demonstrate that they have understood.

Retain the information
The person must be able to hold the information in their mind long enough to use it to make an effective decision. Items such as notebooks, computers, photographs, posters, videos, and voice recorders can help people record and retain information. It may be helpful at the end of the decision-making process to check that the person has retained the information they need. Even if a person can only retain information for a short time, they must not automatically be assumed to lack the capacity to decide – it depends on what is necessary for the decision in question.

Using or weighing information as part of the decision-making process
Sometimes people can understand the information they have been given, but because of their impairment or disturbance in the mind or brain, cannot use it. Or they make a decision because of the impairment or disturbance without understanding or using the information they have been given.
Another common area of difficulty is where a person with an acquired brain injury gives coherent answers to questions, but it is clear from their actions that they are unable to give effect to their decision. This is sometimes called an impairment in their executive function. If the person cannot understand (and/or use and weigh) the fact that there is a mismatch between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated mismatch between what the person says and what they do. This means that in practice it is unlikely to be possible to conclude that the person lacks capacity as a result of their impairment on the basis of one single assessment.
A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information.

Communicate the decision
This was essentially introduced to cover situation where it was impossible to tell whether a person was able to understand, retain and use or balance the information required to make a decision. For instance, in circumstances where people have had a stroke and cannot communicate in any way at all, or people with locked-in syndrome.

Impairment or disturbance in the functioning of the mind or brain
An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- Conditions associated with some forms of mental illness
- Dementia
- Learning disability or Autism
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it

- The effects of drugs and/or alcohol
- Delirium
- Concussion following a head injury
- The long-term effects of an acquired brain injury

It can be temporary or permanent. Waiting to see if a person can recover to make the decision themselves should always be a consideration in the case of a temporary impairment or disturbance. Equally if someone has never been given a choice, they may need support in advance of making a decision to experience what is involved in making the choice. A formal diagnosis is not necessary for the purposes of the Act. It is also not necessary for the impairment or disturbance to fit into a recognised clinical diagnosis (for example in a psychiatric manual). However, the person claiming that an individual lacks capacity must be able to show a proper basis for considering that they have an impairment or disturbance.

Is the person's inability to make the decision caused by the impairment or disturbance in the functioning of their mind or brain?

This is how the impairment affects an individual's ability to make the required decision and has been identified as a key element of the assessment process. Evidence of the relationship between the two must always be clearly made. However, this is not always easy to identify and if it is not possible, then the person cannot be deemed to lack capacity. If this is the case and there are concerns about the person's safety, safeguarding procedures should be followed.

Fluctuating Capacity

Mental capacity can vary between decisions and time of day or periods of time. It may be temporarily affected by other factors such as medication, delirium, alcohol, shock, exhaustion, and pain. This is known as Fluctuating Capacity. A person may have the capacity to make a simple decision, and at the same time may lack the capacity to make a more complex or significant decision. For each patient with fluctuating capacity, it must be considered whether the person is likely to regain capacity and whether or not the decision could wait. Therefore, capacity revisiting may be frequently required, or the person supported to make decisions in advance for times when they are known to lose decision-making ability.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

Lack of Engagement

It is important to distinguish between the situation where the person is unwilling to take part in the assessment, and the one where they are unable to take part. It is always necessary to consider ways in which the person could be persuaded to take part. For example, explaining how helping the assessor will help them. Liaising with others who know the person well should be considered. Giving the

person a choice about who will do the assessment could be considered as are exploring possible reasons for being reluctant to engage.
Ultimately, however, it is not possible to force a person to undergo a capacity assessment. It will therefore be necessary to consider whether there is enough surrounding evidence to come to a reasonable belief that the person lacks capacity if steps are going to be taken on the basis of s.5 MCA 2005. If the stakes are high, for the person or others, then it will be necessary to make an application to the court to decide whether the person has or lacks the capacity to make the relevant decision.

Supported Decision Making
The process by which an individual is supported to participate in the decision-making process.

Unbefriended
Under the MCA 2005 this term refers to an individual who has no-one other than paid carers or representatives to represent their likely views and advocate on their behalf. The person may have no family or friends or may be estranged from their family.

Independent Mental Capacity Advocates (IMCAs)
IMCAs are a safeguard for people who lack capacity to make some important decisions. An IMCA will support and represent an unbefriended person in the decision-making process.

Care Act (2014) Advocate
The duty to provide an independent advocate under the Care Act (2014) applies to:
• Adults who need care and support
• Carers of adults (including young carers)
• Carers of children in transition
• Children who are approaching the transition to adult services
Where two conditions can be met:
• The person has substantial difficulty in being fully involved within assessment, care and support planning and review or safeguarding.
AND
• There is no one appropriate and available to support and represent their wishes

Court Of Protection
A specialist high court which makes decisions relating to people who lack capacity to make a required decision at the time it needs to be made. It deals with decisions about property and financial affairs, and healthcare and personal welfare matters including, in some cases, deprivations of liberty.
The Court also has powers to make decisions about whether a person has capacity to make a particular decision for themselves.
It can make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions, make decisions relating to deprivation of liberty, appoint deputies to act on behalf of people

lacking capacity, decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid, remove deputies or attorneys.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) is a legal provision which became law in April 2009. The safeguards are in addition to and part of the MCA (2005), they do not replace it. It is the legal framework which supports an individual's ECHR Article 5 Rights and prevents an individual from being deprived of their liberty when the person's care and treatment may amount to a Deprivation (as defined by the Acid Test).

Some people need additional protection to ensure they do not suffer harm, especially in situations where delivering the necessary care and/or treatment requires their personal freedoms to be restricted to the point of actually depriving them of their liberty.

These safeguards apply to people in hospitals and care homes registered under the Care Standards Act 2000 – and apply to people in England and Wales.

The Safeguards set out a standard process that hospitals and care homes should follow if they think it will be necessary to deprive a person of their liberty to deliver a particular care plan that is in the person's best interests. By following the MCA DoLS, hospital and care home employees can ensure that people are deprived of liberty only when necessary and within the law.

The DOLS does this by providing:

- An authorisation and review process,
- A representative to act for the person and protect their interests,
- Rights of challenge to the Court of Protection against unlawful deprivation of liberty,
- Right to have the decision relating to the deprivation of liberty reviewed and monitored on a regular basis.

The DOLS apply to anyone:

- aged 18 years and over

And,

- who has been diagnosed as experiencing a mental health illness, disorder, or disability of the mind

And,

- who has not been detained under the Mental Health Act (MHA) 1983,

And,

- who lacks the capacity to give informed consent to the arrangements made for their residence in order to receive treatment and/or care,

And,

- who after an independent assessment the arrangements are found to be necessary and proportionate to protect them from harm.

Liberty Protection Safeguards (LPS)

The LPS were introduced in the Mental Capacity (Amendment) Act 2019. The LPS are due to replace the DoLS and are currently being consulted upon

(March – July 2022) by the Department of Health and Social Care and Ministry of Justice.

Significant changes will include:

- These safeguards will apply to all people over the age of 16
- The safeguards will be applicable to any setting and will include transport arrangements between settings
- The safeguards aim to be integrated at the outset of planning for care and treatment arrangements. This will lead to new Responsible Bodies. They will include the Local Authority, but will also include Acute Trusts and the BSW ICB Body responsible for the provision of CHC funded care. They will have to ensure that anyone who lacks capacity to make a decision for themselves and who are subject to continuous supervision and control are **only** subject to restrictive arrangements if they are necessary and proportionate to the risks identified.

The Acid Test for a Deprivation of Liberty
The threshold for care arrangements which constitute a deprivation is low. The Cheshire West Judgement identified the **Acid Test** which highlights two key questions in relation to a person who cannot consent to care and treatment arrangements:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

If the person is subject to continuous supervision and control (being an inpatient meets this threshold) and is not free to leave, they are deprived of their liberty and a statutory process must be followed to seek authorisation.

Managing Authority
The term given to the provider of care in the DoLS arrangements.

Supervisory Body
The Local Authority who is responsible for assessing and authorising all Deprivation of Liberty applications in residential settings under the Deprivation of Liberty Safeguards**.**
This will become the **Responsible Body** under the LPS arrangements with new Responsible Bodies being added alongside the Local Authority.

Decision Maker
The term for the person who needs the consent of an individual to proceed with arrangements for their care and treatment. They are responsible for ensuring that the individual has an assessment of capacity if there is reasonable doubt about the person's ability to make the required decision.

Family members and informal carers will be decision-makers for actions that they undertake. A care assistant will be the decision-maker if the decision is, for instance, about what clothes to put on that morning. They would not be expected to complete a formal capacity assessment, but to have a 'reasonable

belief' that the person lacks capacity for those decisions and to proceed applying the Best Interests Checklist.

Professionals are the decision-makers for actions they are responsible for. A doctor or other health professional will be the decision-maker about someone's capacity for the treatment they are prescribing, or initiating a care pathway. A nurse will be the decision-maker about the treatment or care that they are delivering or administering. Determining who the decision-maker is, depends on the decision and the context.

Best Interests Decision
If a decision-maker determines that someone lacks capacity to make a specific decision, the decision-maker must then go on to make that decision – this is called a Best Interests decision. A Best Interests decision can only be made after it has been determined that the person lacks capacity.

Best Interests Checklist
A statutory checklist identified to ensure the person is at the centre of any decision-making process.

Best Interest Assessor
The role of the Best Interest Assessor (BIA) was introduced through the DoLS in 2009. Best Interest Assessors undertake independent assessments in accordance with the Best Interests Checklist to determine what is in the best interests of a person whose care arrangements may constitute a deprivation of liberty. By law, BIAs must be social workers, nurses, occupational therapists, or psychologists with two years' post-qualifying experience, who have completed an approved BIA course. Courses are run by universities and refresher training must be completed every 12 months.
A new role of Approved Mental Capacity Professional (AMCP) is proposed under the Liberty Protection Safeguards process. The AMCP is a specialist role that provides enhanced oversight for those people that need it most.

3. Process / requirements

The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, a person must be aged 18 or over.
The Act also introduced new bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate
- The Office of the Public Guardian
- The Court of Protection
- Advance Decisions to refuse treatment
- Lasting Powers of Attorney

3.1 The Independent Mental Capacity Advocate (IMCA)

Advocacy is taking action to help people:

- express their views
- secure their rights
- have their interests represented
- access information and services
- explore choices and options

Advocacy promotes equality, social justice, and social inclusion. Therefore, an IMCA is not a decision maker for a person who lacks capacity, but to support the person who lacks capacity and represent their views and interests to the decision maker, nor are they mediators between parties in dispute.

Referrals to an IMCA **MUST** be considered when:

- There needs to be a decision relating to serious medical treatment.
- A long-term move to different accommodation is being considered

Referrals to an IMCA **MAY** be considered when:

- Care Reviews take place – if the IMCA would provide a particular benefit e.g., continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA MUST be instructed PRIOR to the decision being made. If it is urgent then the decision can be taken without an IMCA, but they must be instructed afterwards.
The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made, they can also challenge the decision maker.

3.2 The Office of the Public Guardian (OPG)

This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the Court of Protection, as requested.
The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies.
Further information regarding the Office of the Public Guardian can be found by the following link: http://www.publicguardian.gov.uk/

3.3 The Court of Protection (CoP)

This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.
The Act provides for the CoP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few

cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges, and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (set examples to follow in future cases).
The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
- appoint deputies to make decisions for people lacking capacity to make those decisions; decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties,
- hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.
Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:
http://www.hmcourts-service.gov.uk/HMCSCourtFinder/
It must be stressed that any reference to the Court of Protection must be discussed with the BSW ICB Director for Corporate Affairs in the first instance. BSW ICB must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection.

3.4 Advance Decisions to Refuse Treatment (ADRT)

A person may have made advance decisions regarding health treatments, which will relate mainly to medical decisions. These should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.
If over the age of 18 years, a person making an advance decision to refuse treatment allows their decision about particular types of treatment to be honoured in the event of losing capacity. This is legally binding and doctors and other healthcare professionals must follow directions.
Professionals must take all reasonable efforts to be aware of any advance decisions that exist, and check their validity and that they are applicable to the particular treatment in question.

An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive and without which they may die) this must be in writing.
Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says the person's decision applies even though their life may be at risk
- Signed by the person or nominated appointee and in front of a witness

- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. You cannot ask for an advance decision to end your life or request treatment in future.
The validity of an advance decision may be challenged on the following grounds:

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act is the criteria for admission are met
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision

3.5 Lasting Powers of Attorney (LPA)

This is where a person (known as a donor), aged 18 or over, with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. LPAs can be friends, relatives or a professional. There are two types of LPA:

- Property and affairs - any financial and property matters
- Personal Welfare - decisions about health and welfare, such as where a person lives, day to day care or consent to medical treatment.

It only comes into effect after the person loses capacity and it must be registered with the Office of the Public Guardian before it can be used.
The person who holds an LPA can only act within the remit of their authority.
Details of the LPA must be recorded in the person's file where there is knowledge of it. It is a legal document.
Once registered, a property and affairs LPA can be used when the donor has capacity, if the donor has specified that in the LPA, and if they have given permission to make the decision. But a personal welfare LPA can only be used if the donor does not have capacity to make the decision. The donor can choose one person or several people as their attorney to make different kinds of decisions.
Important facts about LPAs:

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes a LPA, they must have the capacity to understand the importance of the document.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person, you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

3.6 Court Appointed Deputies

The Court of Protection has powers to appoint deputies to make decisions for people lacking capacity to make those decisions, and to remove deputies who fail to carry out their duties. Anyone acting as a deputy must follow the Act's statutory principles including:

- considering whether the person has capacity to make a particular decision for themselves. If they do, the deputy should allow them to do so unless the person agrees that the deputy should make the decision
- taking all possible steps to try to help a person make the particular decision
- always make decisions in the person's best interests and have regard to guidance in the Code of Practice that is relevant to the situation
- only make those decisions that they are authorised to make by the order of the court
- fulfil their duties towards the person concerned (in particular the duty of care and fiduciary duties to respect the degree of trust placed in them by the court)
- keep, correct accounts of all their dealings and transactions on the person's behalf and periodically submit these to the Public Guardian as directed, so that the OPG can carry out its statutory function of supervising the deputy.

3.7 Clinical Intervention

Decisions that are not covered by the MCA:

- Making a will
- Making a gift (unless they have a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering into marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office

There must always be a presumption of capacity. The flow chart at Appendix 1 tells a practitioner what should happen if a professional is concerned that a person may lack capacity to make a decision at this particular time. It is recognised that a number of different professionals can be involved with persons who may lack capacity and in certain circumstances will contribute their support to the person on behalf of the decision maker.
The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear. The MCA protects people who carry out these day to day actions if they correctly follow the principles in the Act. It stops them being prosecuted for acts that could otherwise be classed as civil wrongs or crimes. By protecting family and other

carers from liability, the Act allows necessary caring acts or treatment to take place as if a person who lacks capacity to consent had consented to them. People providing care of this sort do not therefore need to get formal authority to act.
Legally, people have the right to a private and family life, home, and correspondence, and to stop others from interfering with their body or property unless they give permission. Other decisions many have more lasting or serious consequences such as a change of accommodation. Section 5 of the MCA does not give people caring for or treating someone the power to make any decision on behalf of those who lack capacity to make their own decisions. Instead, it offers protection from liability so that they can act in connection with the person's care or treatment. The power to make decisions on behalf of someone who lacks capacity can be granted through other parts of the Act (such as the powers granted to attorneys and deputies).
If people carry out actions in a way which does not comply with section 5 – for example by making a decision or performing an act which is not in the person's best interests – then they may be held liable for any consequences. A person is protected from liability if they:

- have followed the five key principles which must inform everything when providing care or treatment for a person who lacks capacity,
- have enabled a person, so far as is possible, to make their own decisions
- have taken reasonable steps to establish lack of capacity,
- have reasonable belief that the person lacks capacity,
- have demonstrated their action will be in the person's best interest.

The basis for decision-making should be recorded.

3.8 GP Registration

For GP registration where the adult lacks the capacity to make an application, or to authorise an application to be made on their behalf, an application can be made on their behalf by:

- a relative of that person
- the primary carer for that person
- a donor of a lasting power of attorney granted by that person
- a court appointed deputy for that person.

3.9 Information Sharing

It is important for individuals to be assured that their personal information is kept safe and secure and that practitioners act in accordance with the guidance from the Information Commissioner's Office on the General Data Protection regulation (GDPR) and the Data Protection Act (2018) and Caldicott Principles.

It is important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently. Professionals may wish to refer to specific advice from their professional body regarding information sharing e.g., General Medical Council or Nursing and Midwifery Council guidance.

Colleagues must ensure they are familiar with the BSW ICB Information Governance Policy and have undertaken mandatory Information Governance Training.

Local Safeguarding Partnerships will have multi-agency information sharing policies/protocols in place and staff should ensure they understand and adhere to these.

Golden rules for information sharing:

- Remember that the GDPR and DPA (2018) should not be used as a barrier to share information
- Be open and honest with the person (and/or their family where appropriate) at the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so
- Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. Information may still be shared without consent if that lack of consent can be overridden in the public interest. This judgement must be based on the facts of the case
- Consider the safety and well-being of the person and others who may be affected by their actions
- Ensure that any information sharing is necessary, proportionate, relevant, accurate, timely and secure
- Ensure the decision is recorded along with the rationale behind it

3.10 Contract Monitoring

Where a healthcare provider is unable to demonstrate compliance with any Mental Capacity Act KPI standards or essential standards, they will produce an action plan with timescales that details steps to be taken to achieve compliance. This action plan will be monitored by the appropriate Commissioning Manager, with support from the Designated Nurse.

3.11 Mental Capacity Act & Serious Incidents (SI's)

Serious incidents will be monitored for application of the Mental Capacity Act.

Significant breaches of the Act may meet the threshold for an SI.

BSW ICB is committed to analysing and sharing any learning from incidents and investigations, in order to improve practice and minimise risk of abuse. The National Patient Safety Agency (NPSA) has published a series of definitions covering the full range of harms that are associated with a patient safety incident that should be investigated to identify root cause and enable ameliorating action to prevent recurrence. Misuse of the Mental Capacity Act falls within this definition

The definition of serious incident extends beyond those which affect patients directly and includes incidents which may indirectly impact on patient safety or the organisations' ability to deliver on going healthcare. All serious patient

safety incidents should be reported to the Learning from Patient Safety Events (LFPSE) service.

4. Roles and responsibilities

Designate Chief Executive
The Designate Chief Executive is responsible for ensuring that all services commissioned by BSW ICB are compliant with the Act.

Executive Lead for Safeguarding (BSW ICB Chief Nurse)
The Executive Lead is accountable for ensuring that the services commissioned by BSW ICB are delivered in a way that respects the rights of the individuals, in particular those who are vulnerable and may not be able to take decisions on their own behalf.

Associate Director of Strategic Safeguarding
The Associate Director of Strategic Safeguarding is responsible for ensuring that:

- BSW ICB has policies and assurance systems in place to monitor compliance of commissioned services against Mental Capacity Act Key Performance Indicators.
- The MCA 2005 is an integral component of BSW ICB Commissioning cycle.
- The commissioning and contract management processes are supported to ensure service specifications, invitations to tender and that service contracts reflect the principles of the Mental Capacity Act.
- Provide professional advice to the organisation, teams, and primary care organisations regarding the Mental Capacity Act.
- BSW ICB receive briefing papers detailing activity, practice development trends and potential risks relating to the Mental Capacity Act.
- There is MCA support for BSW ICB serious incident panel process and that reviews include assurance that there is compliance with the Mental Capacity Act 2005.
- Providing BSW ICB leadership on the Mental Capacity Act 2005.

Designated Professionals for Safeguarding Adults, Children and Looked After Children
The Designated Leads are responsible for the provision of expertise, professional leadership, advice, support, and expert guidance, in respect of Mental Capacity and Deprivation of Liberty Safeguards for the population in each of their locality areas in receipt of NHS funded care.
They provide support to the Associate Director of Strategic Safeguarding and to the Chief Nurse to ensure that the responsibilities identified above are carried out and risks and progress against development plans communicated.

Commissioning Managers

- Ensure that service contracts include relevant Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) requirements as laid out in this policy.

- Commissioning Managers are responsible for ensuring that delegated roles such as care management encompass the principles of this policy and there are clear thresholds for escalating concerns to commissioners.
- For people who are unable to make the required decisions at the required time robust best interest processes are in place to protect the individual.
- Commissioning Managers have the responsibility to ensure that any safeguarding concerns regarding commissioned services are raised with the Organisation concerned and reported to BSW ICB Designated professionals.

All colleagues including CHC, Specialist Placements & Section 117 colleagues

- Colleagues undertaking assessments and organising care arrangements have a responsibility to ensure all aspects of their work is underpinned by the MCA 2005 Principles.
- Colleagues employed by BSW ICB may visit provider organisations as part of their role, for example to attend meetings or to carry out their duties. They have a duty to identify to the hospitals or care homes if they think that arrangements made for care and treatment may constitute a Deprivation of Liberty. It is the responsibility of the provider to complete and submit any subsequent DoL application.
- BSW ICB colleagues should discuss with either the BSW ICB Designated Leads for Adult Safeguarding in each of the BSW ICB localities or discuss with the Safeguarding Adult Named Leads in each provider or refer to the DoLS team in each Local Authority area if they have concerns relating to Deprivation of Liberty authorisations for BSW ICB Commissioned care, including NHS providers.
- Attend Mental Capacity Act training appropriate to their role and responsibilities and draw any learning needs to the attention of their manager.
- Consider an individual's ECHR Article 5 rights (Potential DoL) when reviewing care records for consideration of CHC, S117 aftercare or where there is a Community Treatment Order in place (CTO).

5. Training

5.1 There is ELfH MCA e-learning available to all staff currently. This should be undertaken in relation to role and identified within the Personal Development cycle.
This policy will be accompanied by communication of its ratification via the BSW ICB Communications team. This will also provide an opportunity to socialise the imminent changes in the MCA law.
A bespoke level 3 training course for Commissioning, Quality and CHC colleagues planned for June 2022 will include reference to the policy.

6. Equality and diversity

An Equality Impact Assessment (EIA) has been completed for this policy and no significant issues were identified.

7. Success criteria / Monitoring effectiveness

During 2021-2022, BSW ICB LeDeR reviews have identified health and social care system compliance issues with MCA application in practice. The BSW ICB LeDeR Co-ordinator is conducting a training review to establish the need for mandatory MCA training for all providers of care. Equally, it has been identified locally and nationally through Safeguarding Adult Reviews that MCA application is not well understood and applied in practice by both Health and Social Care organisations. The latest Annual Report of the Mental Capacity Act Forum (2019) has made similar findings.
BSW ICB Safeguarding team are currently working on a BSW ICB training strategy. This will include a review of the need to include MCA training as mandatory.
The performance of the Policy needs to be monitored through a variety of means. This includes through the objectives set by the LeDeR steering group and the Safeguarding training strategy for BSW ICB.

8. Review

8.1 This document will be reviewed when the Mental Capacity (Amendment) Act 2019 is ratified in Parliament, or after three years, if there are further delays in its introduction.

9. References and links to other documents

9.1 **Research/Evidence/References that were used to assist with the development of the Policy**

39 Essex Chambers (January 2022) **Carrying out and Recording Capacity Assessments**
https://www.39essex.com/mental-capacity-guidance-note-assessment/

9.1.1 Links to other BSW ICB Policies
BSW ICB Information Governance Policy
BSW ICB Safeguarding Adults, Children and Looked After Children Policy

9.2 Relevant Websites

https://www.mentalcapacitylawandpolicy.org.uk/

https://www.39essex.com/mental-capacity-guidance-note-assessment/

https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

https://www.gov.uk/government/collections/mental-capacity-amendment-act-2019-liberty-protection-safeguards-lps

https://www.scie.org.uk/mca/lps

https://www.hilldickinson.com/sectors/health/liberty-protection-safeguards

https://commonslibrary.parliament.uk/research-briefings/cbp-9341/

https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

10. Review history

Version	Review Date	Reviewed By	Changes Required? (If yes, please summarise)	Changes Approved By	Approval Date

It is essential that the document tracks how it has developed over time.

11. Acknowledgement of external sources / assistance

The following documents were used to assist with the development of this policy:

39 Essex Chambers (January 2022) **Carrying out and Recording Capacity Assessments**
https://www.39essex.com/mental-capacity-guidance-note-assessment/

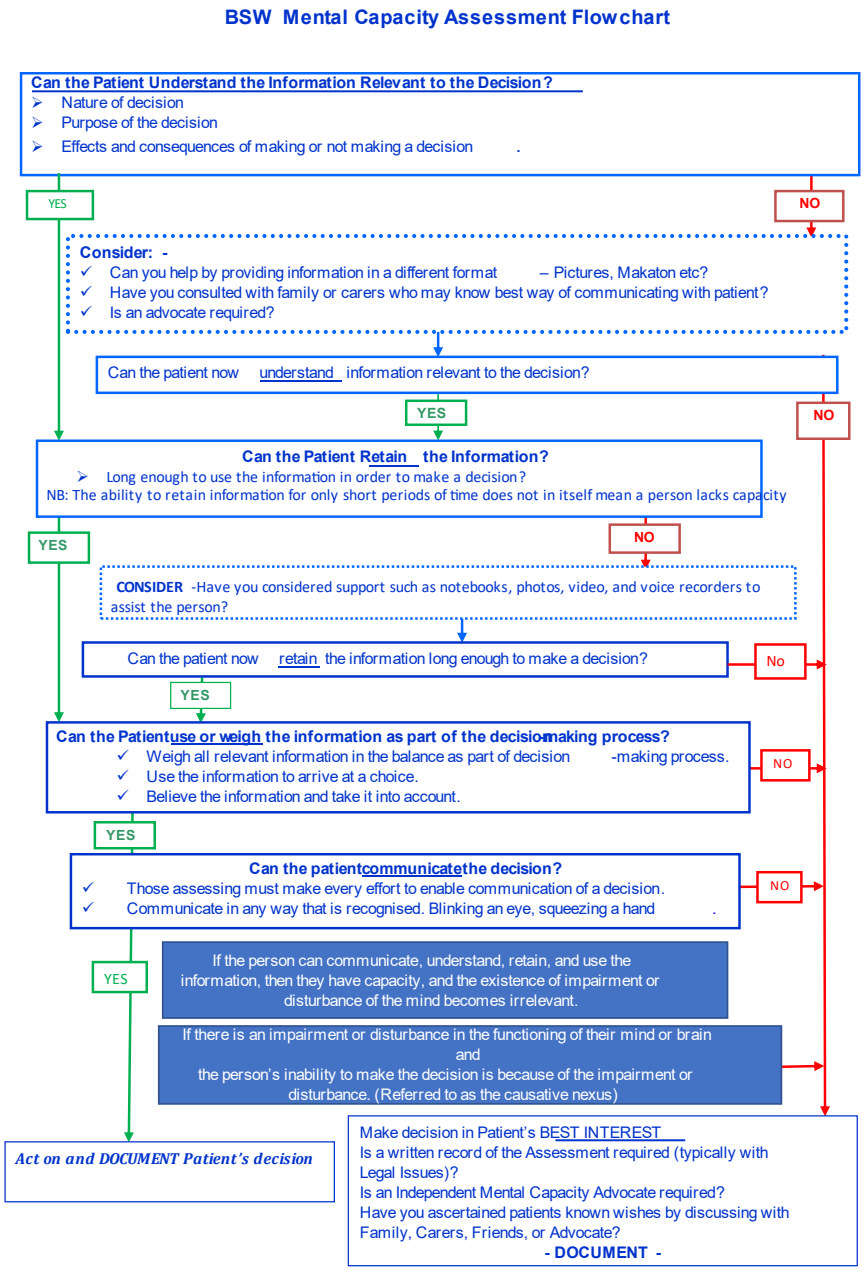
Department of Health and Social Care, Ministry of Justice, Department for Education, and Welsh Government (March 2022) **Draft MCA Code of Practice**
https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

12. Links with other BSW ICB documents

BSW ICB Information Governance Framework [https://intranet.BSW ICBccg.nhs.uk/tools-and-resources/resource-library/policies-and-guidance/information-governance-policies]

BSW ICB Safeguarding Adults, Children and looked After Children Policy [https://intranet.BSW ICBccg.nhs.uk/tools-and-resources/resource-library/policies-and-guidance/patient-policies].

Appendix 1


BSW Mental Capacity Assessment Flowchart
Can the Patient Understand the Information Relevant to the Decision?
Nature of decision
Purpose of the decision
Effects and consequences of making or not making a decision .
YES
NO
Consider: -
Can you help by providing information in a different format – Pictures, Makaton etc?
Have you consulted with family or carers who may know best way of communicating with patient?
Is an advocate required?
Can the patient now understand information relevant to the decision?
YES
NO
Can the Patient Retain the Information?
Long enough to use the information in order to make a decision?
NB: The ability to retain information for only short periods of time does not in itself mean a person lacks capacity
YES
NO
CONSIDER -Have you considered support such as notebooks, photos, video, and voice recorders to assist the person?
Can the patient now retain the information long enough to make a decision?
No
YES
Can the Patient use or weigh the information as part of the decision-making process?
Weigh all relevant information in the balance as part of decision -making process.
Use the information to arrive at a choice.
Believe the information and take it into account.
NO
YES
Can the patient communicate the decision?
Those assessing must make every effort to enable communication of a decision.
Communicate in any way that is recognised. Blinking an eye, squeezing a hand .
NO
YES
If the person can communicate, understand, retain, and use the information, then they have capacity, and the existence of impairment or disturbance of the mind becomes irrelevant.
If there is an impairment or disturbance in the functioning of their mind or brain and the person's inability to make the decision is because of the impairment or disturbance. (Referred to as the causative nexus)
Act on and DOCUMENT Patient's decision
Make decision in Patient's BEST INTEREST
Is a written record of the Assessment required (typically with Legal Issues)?
Is an Independent Mental Capacity Advocate required?
Have you ascertained patients known wishes by discussing with Family, Carers, Friends, or Advocate?
- DOCUMENT -