NHS
Southwark
Clinical Commissioning Group

MENTAL CAPACITY ASSESSMENT (MCA) AND DEPRIVATION OF LIBERTY (DOL) POLICY

IN COMPLIANCE WITH MENTAL CAPACITY ACT 2005

2019-2021

Approved by	Safeguarding Executive Committee
Date approved	
Name and title of originator/author	Musthafar Oladosu, Adults Safeguarding Lead Nurse
Name and title of sponsor	Kate Moriarty-Baker, Director of Quality and Chief Nurse.
Name of responsible committee/individual	Safeguarding Executive Committee
Review date	February 2021
Policy description (Max 50 words)	This policy aims to ensure that no act or omission by NHS Southwark CCG (henceforth referred to as CCG) as a commissioning organisation, or via the services it commissions, is in breach of the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards (2009) and to support staff in fulfilling their obligations.
Target audience	CCG employees
Stakeholders engaged in development	CCG Continuing Health Care Team, CCG Safeguarding Team, CCG Clinical Commissioners, commissioned provider organisations that undertake case management roles on behalf of the CCG – Guy's and St Thomas' NHS Foundation Trust (continuing health care team, learning disabilities team and safeguarding team) and South East London CCGs safeguarding adults leads.
Version number	1.0
Supersedes	0
Implementation plan in place?	Yes
Method and date of dissemination	Intranet, Staff newsletter, Safeguarding Executive Committee meeting
Monitoring method	Complete Review
Frequency	1 year
Responsibility	Adults Safeguarding Lead Nurse
Reporting	Director of Quality and Chief Nurse

Document Review Information

Reviewer Name(s) and Job title	**Change/amendment**
Musthafar Oladosu, Adults Safeguarding Lead Nurse	It should be noted that in July 2018, the Government published a Mental Capacity (Amendment) Bill, which if passed into law will reform the Deprivation of Liberty Safeguards (DoLS). However, it remains unclear when the Bill may pass into law, and then when it may be implemented. This policy will be reviewed when the new law comes into force to bring the CCG and its partner organisations into compliance.

Contents

1 Introduction

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

In developing this policy CCG recognises that the implementation of the Mental Capacity Act is a shared responsibility with the need for effective joint working between agencies and professionals

The Mental Capacity Act (MCA) 2005 covers people in England and Wales who may be unable to make some or all decisions for themselves. The ability to understand and make a decision when it needs to be made is called *'mental capacity'*

The MCA applies to anyone aged 16 years and over and covers a wide range of decisions such as healthcare, personal welfare and financial matters. Everyone working with, or caring for, anyone 16 years and over who may lack capacity must comply with the Act and the associated MCA Code of Practice (2007). The MCA is relevant both to people accessing healthcare and social care services, as well as those who work in these organisations.

1.1 *The MCA is underpinned by five key principles;*

- The presumption of capacity
- Supporting a person to make their own decisions, including taking practical measures as may be required to enable them to do so
- People are allowed to make an unwise decision
- Where an individual is assessed to lack capacity, decisions are made in their best interests
- Decisions made in a person's best interest should be the less restrictive option

1.2 The MCA also incorporates Deprivation of Liberty Safeguards (DoLS). A person may be deprived of their liberty because they do not have the mental capacity to consent to their care arrangements, and additionally there is a high level of care provided by or on behalf of the state to ensure their safety and wellbeing.

2 CCG roles and responsibilities

The MCA is particularly relevant for the work of CCG in the following areas;

- CCG commissioned services
- CCG primary funder responsibilities for individually funded care contracts (for example, Continuing Healthcare or MHA Section 117 aftercare)
- Community partner responsibilities as a key statutory body

Refer to National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (revised) Para 320 – 322. The document incorporates the NHS Continuing Healthcare Practice Guidance.

2.1 *Commissioned services*

The CCG has a responsibility to ensure services it commissions are MCA compliant. All commissioned services need to demonstrate that they have in place a:

- Mental Capacity Act Lead,
- Mental Capacity Act Policy
- Staff trained in principles sets out in Mental Capacity Act 2005 at level commensurate to their roles and responsibilities. See appendix 1

2.2 The NHS England MCA Guide for CCG's (2014) sets out in more detail what assurance CCG's should reasonably expect to see from hospitals and other services providing care to people aged over 16 who lack capacity to consent to some or all of their care and treatment.

2.3 *MCA Assurance frameworks*

Type of service	Assurance arrangements
NHS providers where standard contract forms basis of contract	• MCA assurance as outlined in the Standard Contract (evidence of MCA Lead, Policy and Training) • In addition, locally agreed quality assurance indicators covering MCA to be completed and returned by the end of agreed reporting cycle. • MCA indicators and evidence outlined in the report to be presented for discussion at annual provider's CQRG or equivalent.
Spot purchase contracts	Assurance of MCA activities is gained through individual care reviews conducted at least yearly

2.4 *CCG primary funder responsibilities*

The CCG may be the primary funder of care for people who require individually commissioned placements. This may be evident through Continuing Healthcare, mental health commissioning (for example Section 117 aftercare), or children's continuing healthcare commissioning for people between the age of 16 and up to 18 years old.

In these cases, even though the care plan may have been arranged by another NHS service commissioned by CCG, (for example Guy's and St Thomas' GSTT Adults Continuing Healthcare Team, Hospital Discharge teams or South London and Maudsley SLaM through care co-ordination arrangement), the CCG assumes responsibility for the care arrangements by virtue of being the commissioner funder of the care package. CCG must assure itself that the care arrangement it commissions is fully compliant with relevant laws including the MCA 2005. CCG will also ensure, where required, that appropriate legal advice is available to staff arranging and managing the care package on behalf of the CCG.

Typically, people who require individually commissioned placements need to make complex decisions about their future. This could involve decisions about the amount and type of care to receive, and the most suitable place in which to receive it. People who do not have mental capacity to make these complex and serious decisions need

to have decisions made for them in accordance with the process outlined in the MCA. For a person whose mental capacity may be in doubt, the decision maker must consider the question: *"What should my care and support arrangements be?"*

In answering that question, the necessary care arrangements to keep someone who lacks capacity safe and cared for could impinge on their fundamental human rights and freedoms such as their liberty, autonomy and privacy. There are two human rights that CCG's need to give particular attention to;

- Right to liberty
- Right to a private and family life

It should be noted that because of the potential impingement on a person's rights and freedoms, the care plan may be challenged, and open to legal scrutiny; the CCG may be asked to justify the care arrangements it has funded in a court of law.

As responsible primary funders for individual care arrangements, it is essential that the CCG is assured in three key areas;

- *Assessment* of a person's mental capacity is completed
- The decision about care arrangements are made in a person's *best interest* of the person where they lack capacity to do so.
- If there is potential impingement on a person's rights and freedoms arising from the proposed care arrangement that may amount to a deprivation of their liberty; *correct legal safeguards* are in place to protect the individual. See section 4

3 Care Arrangement and Capacity Assessment

Commissioners need to receive specific assurance that an assessment of capacity has been completed in the following scenario;

- person is aged 16 or over
- there is reason to doubt a person's capacity
- CCG are primary funders of care
- either a new or significantly amended care plan/arrangement is proposed
- a person is not proposed to be detained under section 2/3 of the MHA

See appendix 2 for what should be included in a capacity assessment

3.1 *Best Interest decision*

If a person has been assessed as not having capacity to make a decision about their future care arrangements and a new or significantly amended care arrangement is proposed for them, commissioners must be assured that a Best Interest decision has been made on behalf of the person. The best interest decision should cover two main elements;

- Compliance with the Best Interest checklist outlined in the MCA Code of Practice
- Analysis of available care options,

See appendix 3 for what should be included in a best interest decision

4 Deprivation of Liberty Safeguards (DoLS)

A person may be deprived of their liberty if;

- the person is 18 or over (different safeguards apply for children, see 4.4)
- the person is suffering from a mental disorder.
- the person is under 'continuous supervision and control' and 'not free to leave'
- the person lacks capacity to consent to the care arrangements which deprive them of their liberty
- the state is involved in their care arrangements

Article 5 of the Human Rights Act states *"everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law"*.

4.1 *Deprivation of Liberty Safeguards (DoLS) in hospital and care home settings*

DoLS is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

The DoLS scheme is used to assess and authorise deprivations of liberty in care home, hospice and hospital settings. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in that patient or resident's best interests. Commissioners and those commissioned by the CCG to plan, deliver and or coordinate care should bear in mind that extra safeguards are needed if the restrictions and restraint that would be required as part of their care will deprive them of their liberty. The care homes or hospitals must ask the local authority, usually where the person is ordinarily resident, if they can deprive the person of their liberty. Please refer to the table below for outline of roles and responsibilities in MCA/DoLS.

4.2 *Deprivation of Liberty in other settings*

Following the Supreme Court judgment in Cheshire West and Chester Council v P (2014), a deprivation of liberty that is *"attributable to the State"* can occur in other community settings, including supported living arrangements and in private domestic settings.

Where deprivation of liberty occurs through care delivered, arranged and or funded by social services or NHS organisations, which are in law treated as *"State agents"* there must be lawful authority for that deprivation. Such authority is required to comply with Article 5(1) of the European Convention on Human Rights (ECHR), made part of English law by s.6 of Human Rights Act 1998, which places strict limits upon the circumstances under which individuals can be deprived of their liberty.

It is essential, as far as practicable, that any proposed care arrangements that deprives someone of their liberty are authorised before they occur. If a person is unlawfully deprived of their liberty they may wish to seek compensation from one or more of the state bodies involved in their care or ought to be aware of their situation. This could include the CCG.

Deprivations of Liberty can be authorised either by the Local Authority DoLS service or directly by the Court of Protection (CoP). See appendix 4, 5 & 6 to ascertain how deprivation of liberty needs to be authorised.

4.3 MCA: Outline of key roles and responsibilities		
	NHS provider/ case manager/ care coordinator (external to CCG)	CCG CHC/ MH/ Children's Commissioner should
Capacity Assessment (Decision: deciding on whether or not to consent to proposed care arrangement)	Commissioner needs to ensure that a capacity assessment is completed prior to consideration of new care arrangement. Decision maker is the health/social care professional who put together the care plan/arrangement which the CCG has been asked to fund.	Ensure that funding request includes capacity assessment. This ideally should be requested at the CHC Panel/once a decision has been made that the person's care package/placement will be funded by the CCG. Document MCA/Best Interest decision as appropriate. See appendix 2
Best Interest decision	If MCA indicates lack of capacity, the decision maker should make a best interest decision regarding the care arrangement they have proposed in line with the MCA Code of Practice.	Request completed Best Interest decision and scrutinise for quality. See appendix 3

4.4 DoL: Outline of key roles and responsibilities			
Deprivation of Liberty See Appendix 4, 5 & 6	Proposed care arrangements will be for an adult in a registered care home or hospital (including for short term placement known as respite)	Notify Local Authority DoLS team that the person is likely to be deprived of their liberty as a result of proposed care arrangements. If the placement is for respite, indicate duration and frequency of placement)	Ask NHS provider organisation whether local authority DoLS team have been informed of possible deprivation. If this has not happened, inform relevant local authority.

	Proposed care arrangements will be For a child aged 16-17 or an adult, in any setting that is not a registered care home or hospital setting	Put together a clear care plan and complete capacity assessment and best interest decision as required. Complete 'clinical' Court of Protection forms as directed by commissioner	Commissioner should Inform Adults Safeguarding Lead Nurse of person in this category. The Lead Nurse will collate appropriate paper works such as Court of Protection paperwork. Where required and through Adults Safeguarding Lead Nurse, CCG will seek legal advice in compiling appropriate documents for Court of Protection application. Inform case manager/ service provider when deprivation is authorised.

4.5 *Objection to Deprivation of Liberty*

A person is legally entitled to challenge their deprivation of liberty in a court of law. As primary funders, the CCG may well be asked to be a party to court proceedings. If this is the case, the CCG is likely to be asked to provide evidence of previous capacity assessment and best interest decisions and may be asked to complete fresh assessments. The precise nature of what is expected from the CCG is different with each case and would be specified by the court.

5 Children and deprivation of liberty

If a child under 16 is not under a formal care order, his/her parents can authorise deprivation of liberty in the exercise of parental responsibility, for instance, in a hospital, or NHS facility or day care or with a private foster carer, regardless of the child's personal mental capacity. Where consent via parental responsibility is lacking, deprivation must be approved through application to Court of Protection.

Children aged 16 and 17 years are entitled to the full protection of ECHR, art 5 irrespective of their capacity to consent to the relevant care and treatment. Therefore, if valid consent is not provided by the young person, any confinement which would amount to deprivation of liberty will need to be authorised by the state; in such cases this will mean that a public authority including the CCG will need to apply to the Court of Protection to rule on lawfulness of the deprivation.

6 Tenancy

A person without capacity may have to take out or relinquish a tenancy as part of their care arrangements. This is a serious decision that may impinge on a person's right to a private and family life. Tenancy with regards to a person who lacks capacity to consent

to its terms is usually dealt with by the Court of Protection and the person may need a litigation friend to represent them before the court.

Commissioners should engage in discussion with their case managers/care coordinators to ensure the correct legal pathways are followed. Support and advice on this can be provided by the CCG Safeguarding Adult Team. London Borough of Southwark Clients Affairs Team might also be able to provide guidance and or inputs on case by case basis.

6.1 *Dealing with personal financial/property issues*

Commissioners should assure themselves that case managers/care coordinators identified people who lack capacity in matters of moving out of their property to a nursing home and or who may need support in managing their personal finances because of care arrangement CCG commissioned. Difficulties with managing personal finances may impact greatly on a person's autonomy and dignity and may also amount to deprivation of their liberty. Commissioners may need to support the case manager/care coordinators to seek appropriate advice on this matter. Advice and guidance on this can be provided by the CCG Safeguarding Team.

7 Summary of CCG's responsibilities

7.1 *As a primary funder*

The CCG needs to assure itself that good MCA practice is being followed in the care of people who lack capacity; are receiving individually funded care arrangements, and that their rights and freedoms are being supported in accordance with the law. The Commissioner will need to refer to the CCG MCA Assurance Checklist (appendix 4) for each new care arrangement funded by the CCG, or where there has been a *significant* change in existing care arrangement. To determine what is *significant change* in this regard, commissioners need to consider if the change(s) will bring about measure(s) which further deprive(s) the person of their liberty.

7.2 *CCG wider MCA responsibilities*

As a statutory member of the Safeguarding Board, the CCG has a responsibility to work in partnership with other partner organisations to raise MCA awareness and implementation across health in Southwark.

7.3 Executive Lead for MCA

The executive lead for MCA is the Director of Quality and Chief Nurse. The executive lead is responsible for providing assurance to the Governing Body that the CCG is meeting its statutory duty with regards to MCA.

7.4 *Commissioners*

Commissioners are responsible for ensuring MCA compliance clauses are included in prospective tenders, service specifications, contracts, and assurance arrangements for new services.

Commissioners of individually funded care arrangements are responsible for ensuring the CCG MCA assurance checklist is completed, and to act accordingly to address any identified deficits

Commissioners of individually funded care arrangements are responsible for monitoring and managing compliance with contractual obligations by provider services, through a case review process.

Commissioners of individually funded care arrangements are responsible for alerting relevant CCG managers and Safeguarding Team when legal advice may be required.

7.5 *CCG Adults Safeguarding Lead Nurse*

The Adults Safeguarding Lead Nurse is the MCA/DoLS lead, subject expert for the CCG and the first point of contact for any complex MCA issues highlighted by the Commissioners. The Adults Safeguarding Lead Nurse is the CCG representative on external MCA groups and forums.

The Adults Safeguarding Lead Nurse is responsible for exploring best practice and being up-to-date with relevant case laws on the subject including using this information to advice and support relevant CCG employees as well as the Governing Body.

The Adults Safeguarding Lead Nurse is responsible for producing reports on how the CCG complies with MCA in the CCG Safeguarding Annual Report and to update the Safeguarding Executive Committee at regular intervals.

7.6 *All CCG staff*

- Are responsible for complying with these guidelines
- To attend training/ awareness sessions. See Appendix 1
- To make their line manager or Adults Safeguarding Lead Nurse aware of any situation they are aware of in their role which may amount to a breach of MCA (2005).

Appendix 1

Training Matrix

The National Mental Capacity Act Competency Framework provides a framework for the CCG to ensure staff members are trained appropriately for their role and responsibility

Staff Group	Staff members	Level of training	Method and Frequency
A	All CCG staff	Basic knowledge	E-learning 3 yearly
C	Commissioners, CCG Executive Lead for MCA CCG Governing Body Lead for MCA	 As per staff group A, plus knowledge relevant for commissioners.	As above and; 3 hours face to face training provided 3 yearly
E	CCG MCA Lead	As per staff group A and C, and additional knowledge	As above and additional professional development; Attendance at seminars and study days. Evidence of reflective practice

Appendix 2

Minimum information expected in a mental capacity assessment

Information required	Accompanying Notes
Name and details of the service user	
What is the specific decision relevant to the capacity assessment?	*The decision should be person centered. An example of a relevant decision where CCG funded care is planned might be;* ***'What should my care arrangements be?'***
Who is carrying out the capacity assessment?	*The person completing the assessment should be the person most relevant to the decision, and /or who has greatest responsibility for the decision. In terms of assessing capacity for care needs, this is not always a clinician. It could be the discharge nurse, case manager/care coordinator, occupational therapist or other relevant professional.*
Has the person been supported to enable them to make their own decision?	*The first three principles of the MCA are aimed at enabling people to make their own decisions. It is crucial that the assessor evidences what support has been provided throughout the assessment to enable a person to make their own decision, if possible.*
Diagnostic Assessment • Is there an impairment or disturbance in the functioning of the person's mind or brain?	*The Diagnostic Assessment and Functional Assessment make up what is known as the 'two stage' test of capacity.*
Functional Assessment • Can the person understand the information relevant to the decision? • Can they retain that information long enough to make the decision? • Can they use or weigh up that information as part of the process of making the decision • Can they communicate their decision, by any means available to them?	*The capacity assessment must have detailed information relevant to each part of the capacity assessment.* *This could include, for example, details on the questions asked by the assessor to probe understanding, and the answers received.* *The person must be able to understand, retain, weigh up and communicate all relevant factors to the decision, to be assessed as having capacity.* *Conversely, If they are unable to do any aspect of the functional assessment, and the inability is due to impairment of brain or mind, only then can a person be said to lack capacity for that decision.*
Conclusion	*Does the person mental capacity to make the decision, or not?*

Appendix 3

Minimum information expected in a Best Interest decision

Information required	**Accompanying Notes**
Details of the decision maker	*This is likely to be the same person as who carried out the capacity assessment*
Is the person likely to regain capacity? Can the decision be delayed?	*Yes or No*
What are the views of the person who lacks capacity, including past and present wishes and feelings, beliefs and values?	*Case Law indicates that the views, wishes, feelings and beliefs of the person, both present and past have become increasingly relevant when considering their best interest.*
Has there been consultation with other relevant people for their views about the person's best interests.	*This should be where practicable and appropriate. The people who have been consulted should be listed, and their views documented.*
Does this decision meet the criteria for an Independent Mental Capacity Advocate?	*In the case of a serious decision, such as a change of accommodation, if the person does not have any friends or family members willing to support the person, it is very likely that an IMCA should be instructed*
Is there a valid Power of Attorney for health and welfare, or a court appointed deputy?	*A valid Power of Attorney or Court Appointed Deputy may have legal jurisdiction to make the best interest decision*
Is there another, least restrictive option?	*It is crucial that, for serious decisions such as changing accommodation, all options have been laid out and the benefits and burdens of each option considered. This must be presented to the CCG for assurance.*
Have all parties agreed that the option chosen is in the person's best interests?	*If there is any disagreement amongst parties what is in a person's best interest with a serious matter such as their care arrangements, the Court of Protection may be needed to adjudicate.*

Appendix 4

Commissioner's MCA checklist: should be completed prior to procurement of an individually funded care arrangement.

Client Identifier:				
	YES/NO	Comments	Name	Date
Has Capacity Assessment been completed specifically for this decision?				
Is there a robust Best Interest decision?				
Are the different options been considered?				
Are the care arrangements potentially depriving the person of their liberty?				
If the person is deprived if their liberty and the person is an adult to be accommodated in a registered care home or hospital, have the DoLS team been informed?				
If the person is an adult, deprived of their liberty and **are not** in a registered care home or hospital, have the CCG arranged a deprivation of liberty via the Court of Protection				
If the person is deprived of their liberty and is a child aged 16 and 17 years, have the CCG arranged a deprivation of liberty				

via the Court of Protection?				
Does the person need to end/start a tenancy?				
Is the person leaving their own property? What arrangement do they have in place for its future management /decision				
Are we assured that the person does not have a need for personal financial management?				

Appendix 5

Some examples of what constitute deprivation of liberty in the community

The Law Society suggests that the following features may constitute liberty-restricting measures in community based home environment:

- The provision of physical support with the majority of aspects of daily living, especially where that support is provided according to a timetable set not by the individual but by others;
- The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);
- The regular use of restraint by family members or professional carers which should always be recorded in the individual's care plan;
- The door being locked, and where the individual does not have the key (or the number to a key pad) and is unable to come and go as they please, strongly suggests that they are not free to leave;
- The individual regularly being locked in their room (or in an area of the house) or otherwise prevented from moving freely about the house;
- Use of medication to sedate or manage behaviour, including PRN.

These questions may help Commissioner/Care Coordinator establish whether an individual is deprived of their liberty in this context:

- Is the person prescribed or administered medication to control their behaviour, including on a PRN basis;
- What level of support is provided with aspects of daily living? And is that support provided to a timetable set by the individual or by others?
- Is technology used to monitor the individual's location within the home or to monitor when they leave?
- Does the individual's care plan provide for the regular use of restraint? If so, under what circumstances and for how long?
- Is the door to the individual's home locked? If so, do they have the key (or the code to a key pad)?
- Are they free to come and go from their own home unaccompanied as they please?
- Are they regularly locked in their room (or an area of their home) or otherwise prevented from moving freely about their home?
- Are restrictions placed upon them by professionals as to who they can and cannot see?

Court of Protection (COP DOL10) application form can be found here

Appendix 6: Community DoL flowchart