Northern, Eastern and Western Devon
Clinical Commissioning Group

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Linked strategies, policies and other documents	Safeguarding Adult Policy Safeguarding Children Policy Operational Plan

1. Introduction

1.1 The Mental Capacity Act 2005 (MCA/the Act) is intended to protect the rights of individuals to make their own decisions as well as providing a legal framework for situations where a person may be unable to make decisions due to impairment of the mind or brain. This framework includes a right to independent advocacy in some circumstances (Independent Mental Capacity Advocates or IMCAs).

1.2 The Act applies to anyone aged 16 years or over (in England and Wales).

1.3 The Act also includes provisions for adults (18 and over) to make arrangements for a time when they lack capacity including power of attorney and advance decisions to refuse treatment.

1.4 There is a statutory code of practice to accompany the Act. Health and social care staff must have regard to the code of practice when supporting anyone who may lack capacity to consent to relevant care or treatment.

1.5 The MCA was amended by the Mental Health Act (MHA) 2007 to introduce the deprivation of liberty safeguards (DoLS). The safeguards also have an accompanying code of practice. They were implemented in 2009. They provide a framework for lawful detention for people who lack capacity to consent to their care or treatment in care homes or hospitals. They are intended as a safeguard against arbitrary detention and provide access to a right of appeal for people who are deprived of their liberty. Other safeguards include periodic independent assessments and increased access to advocacy.

1.6 Deprivation of Liberty can occur in any setting. When it is necessary for a person who lacks mental capacity to consent to their care and residence to be deprived of their liberty for their own safety in any setting other than a registered care home or hospital, the deprivation must be authorised by the Court of Protection.

2. Purpose of this policy

2.1 The purpose of this policy is to outline the responsibilities of Northern, Eastern and Western Devon Clinical Commissioning Group (the CCG) in applying the Mental Capacity Act and in relation to deprivation of liberty (outside the MHA).

2.2 The policy should be read in conjunction with the codes of practice.

3. Roles and Responsibilities

3.1 In April 2014, NHS England published, Mental Capacity Act 2005: A guide for clinical commissioning groups and other commissioners of healthcare services on Commissioning for Compliance. This guide states:

"CCGs have responsibility for commissioning high quality care and treatment. An essential element of this is ensuring providers of healthcare understand the Act, apply it to practice and monitor compliance. CCGs are seeking assurance that the Act is embedded in the work of organisations with their patients. […] The CCG is responsible for ensuring that all the services it commissions for people aged over 16 demonstrate compliance with the MCA."

3.2 The named responsible MCA lead in NEW Devon CCG is the designated MCA and deprivation of liberty safeguards lead practitioner within the safeguarding team. The main responsibilities of the post are to ensure the MCA, MHA and DoLS are understood and implemented across the CCG and to ensure CCG commissioned services are meeting their statutory obligations. This includes quality improvement, audit, quality assurance, training and provision of guidance, advice and support. The role includes working with the court of protection on behalf of the CCG where necessary and supporting others with this as required.

3.3 The MCA lead is accountable to the head of safeguarding, who is accountable to the Chief Nursing Officer, a member or the executive team and ultimately the Governing Body, which has overall accountability for statutory responsibilities.

3.4 The Quality Committee of the Governing Body has specific responsibility to ensure the CCG is discharging its statutory responsibilities appropriately with regard to the Mental Capacity Act including deprivation of liberty safeguards.

3.5 All CCG employees have a responsibility to uphold the principles of the MCA and fulfil their positive obligations in relation to any deprivation of liberty. Professionally qualified staff members have additional responsibilities to ensure their learning and development regarding the MCA and DoL is kept up to date.

3.6 Any employee working directly with people who may lack capacity must have regard to both codes of practice and seek professional supervision as required.

4. Assurance and Monitoring Compliance

4.1 The CCG will work with providers to ensure that services are compliant with the MCA including seeking evidence relating to:

- Up to date policies

- Named leads in place
- Training programmes and uptake
- Clear guidance on consent, advance decisions, and power of attorney
- Records of capacity assessments and best interest decisions
- Appropriate use of IMCA
- Appropriate use of DoLS
- Procedures for deprivation of liberty outside care homes or hospitals
- Providers own internal governance, reporting and case audit

4.2 The CCG will also monitor compliance through the NHS Standard Contract and service conditions, quality and contract monitoring meetings.

5. Court of Protection

5.1 There may be situations where it is necessary for the CCG to cooperate with or make an application to the court of protection. This will usually be where the CCG is funding care or treatment.

5.2 The CCG may be party to proceedings brought to challenge a deprivation of liberty safeguards authorisation granted by a local authority. In these situations, it will consider with the local authority and the provider whether it is necessary for each party to have separate legal representation within the proceedings.

5.3 The CCG may be responsible to make an application to the court of protection, for example where a person in receipt of fully funded continuing healthcare or 117 funding is deprived of their liberty in a setting other than a care home or hospital. See Appendix 3. The CCG will agree with the provider responsibilities in relation to each application.

5.4 The CCG may be an interested party in applications to the court of protection in relation to other matters such as serious medical treatment, disputes over whether a person has mental capacity, what care or treatment is in their best interest, where they should reside or with whom they should have contact. In these situations, the CCG will take legal advice as to whether it should apply to be joined as a party to the proceedings depending on individual circumstances.

5.5 Section 49 of the MCA makes provision for the court to require a local authority, or an NHS body, to arrange for a report to be made by one of its officers or employees, or by such other person as the authority, or the NHS body, considers appropriate. Appendix 2 includes guidance to clarify responsibilities in relation to section 49 reports.

6. Children under the age of 16

6.1 Although the MCA does not apply to people under the age of 16, the CCG has positive obligations in relation to article 5: right to liberty for people of all ages. This includes taking steps to ensure that any deprivation of liberty is in accordance with a lawful procedure.

6.2 Where the CCG is directly funding the care or treatment of a child, it will consider whether the care may amount to a deprivation of liberty, and if so, take steps in cooperation with the relevant local authority children's services to ensure that the deprivation is authorised. See Appendix 4

6.3 The CCG will also seek assurance from commissioned providers of services to children that they have taken steps to consider whether the care may amount to a deprivation of liberty. Where relevant, providers must notify the CCG (MCA DoLS lead) so that appropriate steps can be taken in cooperation with the relevant local authority.

Appendix 1 Practice Guidance

This guidance is intended for CCG employees working with people who may lack capacity. It should be read in conjunction with the policy and codes of practice. The guidance includes:

The Principles of the Act

The Mental Capacity Act has five key principles:

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

If there is any reason to doubt the person's ability to make decision or if it has been called into question, then there is an expectation that it will be assessed. It is for the assessor to show on the balance of probabilities that the person cannot make decision by applying the statutory test of capacity.

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

It is necessary to consider what might help or support the person to make the decision and provide whatever support is practicable in the circumstances. For example, it may be relevant to consider the best time and place to speak to the person where the person will feel at ease, whether the person has any

communication needs and whether a friend or relative could help the person feel at ease or help the assessor understand the person's method of communication.

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

It is important to acknowledge the inherent subjectivity of decision- making. It is not legally possible to conclude that a person lacks mental capacity to make a decision solely on evidence of decisions or actions that seem to place the person at increased risk of harm. These, in addition to a known or suspected impairment of the mind or brain may indicate the need for further assessment. Assessment of capacity and conclusions must make reference to the functional test.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

The legal principle of "best interest" under the MCA only applies when it has been established that a person lacks mental capacity to make the relevant decision. Best interest is to be interpreted holistically and must take into account the ascertainable wishes of the person as well as the views of anyone else interested in the care and treatment of the person.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedoms.

Whenever care or treatment is proposed that conflicts with the wishes of the person, it is important to consider whether the measures are necessary and proportionate to the risk, including consideration of any negative effect on the person from having their wishes over-ridden. It is also essential to consider the right to respect for private and family life.

Assessing Capacity (the functional test)

Anyone who would seek consent as part of their work should be competent to assess capacity. The person who is providing or organising care or treatment will usually be the one to assess whether a person has capacity to consent to that care or treatment. Specialist advice should be sought where appropriate. For example, it may be necessary to seek advice about a person's understanding or cognitive abilities. That advice should then be taken into account as part of the assessment.

Anyone who claims a person lacks capacity or intends to act in their best interest under the Act must be able to show, on the balance of probabilities, that s/he lacks

capacity to make the particular decision at the time it needs to be made. This means demonstrating it is more likely than not that s/he lacks capacity to make the decision.

In most cases, a capacity assessment takes the form of a conversation or series of conversations with the person about the decision that needs to be made. The outcome of the assessment must be based on the statutory test of capacity:

The role of relatives and carers in the assessment of capacity is not clearly set out in the code of practice. There is no legal duty to consult as exists with best interest decisions. It may be that there is someone who knows the person well who can assist with effective communication to support the person to make their own decision. It would be best practice and in keeping with the second principle of the Act to involve a supporter in these circumstances subject to the usual considerations regarding information sharing and consent. It may be helpful to speak to the supporter in advance of the meeting to clarify their role in the discussion, for example, the importance of being careful not to speak for the person during the assessment. Exceptionally, if there are concerns about undue influence, it may be necessary to arrange to see the person on their own at some stage.

Some people have particularly complex presentation of mental capacity such as fluctuating capacity or difficulties with executive reasoning. In these circumstances, it may be helpful to take into account contextual information including observations of family members, friends and carers when assessing mental capacity. It is important to ensure that information provided is evidence-based rather than anecdotal and that it relates to the person's ability to understand, retain, weigh and use information for the specific decision in question. Relatives may have well-founded concerns about a person's safety which should be taken into account; however, the assessor must carefully consider the role of this information in relation the third principle of the Act. In some situations, it may be more appropriate to address concerns through robust risk management than the framework of the Mental Capacity Act. If a relative disagrees with a professional opinion relating to a capacity assessment, it would be appropriate to take specialist advice or obtain a second opinion.

A person is not able to make a decision if s/he is assessed as unable to do any one of the following because of an impairment or disturbance in the functioning of the mind or brain:

1. Understand the information relevant to the decision

Tips for assessment:

Make sure it is clear what decision is to be made. Have a clear idea of what information is considered "relevant" that the person must understand in order to make the decision. Relevant information will always include the nature of the decision, the reason why the decision is needed, the likely effects of deciding one way or another, and the likely effects of making no decision at all. It is not necessary

for the person to comprehend every detail of the issue but needs to comprehend the salient or most important details. It is important not to assess someone's understanding before they have been given relevant information about a decision. Explain the relevant information as clearly and simply as possible. It may need to be explained more than once. It may need to be explained in a different way, with visual cues or reminders. To test a person's understanding, start with concrete questions. Subjective questions such as "how do you feel about living here," may be more difficult for the person to answer. Make sure the person feels able to say, I don't know or I'm not sure. After a few minutes, ask the person to give a rough explanation of what has been discussed. If a person is only able to answer yes and no questions, understanding can be assessed by repeating the question worded in a different way to check that the person has understood and not just given a repetitive response.

2. Retain that information

Tips for assessment:

It is necessary to retain information only long enough to use it and weigh it and come to a decision. It may be helpful to consider in advance, given the nature of the decision, how long would it reasonably take the person to consider and reach a decision and proceed accordingly. It is not necessary for the person to spontaneously recall information or to retain information long enough for the decision to be implemented, although this may have other practical implications.

3. Use or weigh that information as part of the process of making the decision

Tips for assessment:

To test the person's ability to use and weigh up information, if possible speak to the person about what is important to them and how they have come to the decision. Keep in mind that individuals may give different weight to different factors. For example, a person may legitimately value independence and familiarity over physical safety or comfort. The MCA does not rely on "lack of insight" and this phrase does not feature in the functional test or the code of practice.

4. Communicate their decision (in any way).

Tips for assessment:

Communication may be verbal, using sign language, or by any other means. This part of the test may not be met, for instance, if a person is unconscious or has the rare condition sometimes known as 'locked-in syndrome.'

Finally, the assessor must show that it is more likely than not that the inability to understand, retain, weigh up or communicate is caused by the impairment or

disturbance of the functioning of the mind or brain. If the impairment is temporary, the assessor should make clear that the assessment will need to be reviewed.

Clear records must be kept relating to any capacity assessment. Records should be proportionate in length and detail to the gravity of the decision. It is important that records of mental capacity are decision-specific. It is not acceptable in law or in practice to make global statements about mental capacity (i.e. person has/lacks capacity). If the person does not have an impairment of the mind or brain, it should not be necessary to assess capacity. If, on balance, it was decided that there was no reason to doubt the person's mental capacity to consent to the specific issues, and therefore no assessment of capacity was carried out – it may be appropriate to briefly record this. If a capacity assessment has been carried out, records should include, at minimum, the following information:

- the specific decision to be made
- details of the impairment of/or disturbance in, the functioning of the mind or brain and how it effects the person's ability to make this decision.
- steps taken to maximise the person's ability to make the decision
- the information relevant to the decision and how it was explained to the person
- whether the person could understand, retain, weigh up the relevant information and communicate their decision, giving examples

Advance Decisions to refuse medical treatment

The MCA allows anyone age 18 or over who has mental capacity to make a decision about medical treatment, to set out a refusal of any specific treatment to be binding at any point in the future were they to lack capacity in relation to that decision.

Advance decisions may be written or verbal, but must state precisely what treatment is to be refused, in medical OR everyday language. It may also set out circumstances when the refusal should apply including possible future changes.

There is no set form for a written advance Decision. Healthcare professionals should record verbal advance decisions in a person's healthcare record.

Advance decisions to refuse life-sustaining treatment must be in writing, signed and witnessed and must include a statement saying that it applies even if life is at risk.

Professionals must follow a valid and applicable advance decision, even if they think it goes against a person's best interests. Professional must start from the assumption that a person had capacity at the time they made the advance decision unless they are aware of reasonable grounds to doubt that.

An AD is not valid if:

- The person has withdrawn it while they had capacity.
- It is overridden by a later LPA that relates to the specified treatment
- The person has acted in a way that is clearly not consistent with the decision

It is not applicable if:

- The person who made it has capacity to consent to or refuse the treatment.
- It does not refer specifically to the treatment in question
- Any circumstances included in the AD are absent.
- There are reasonable grounds for believing that circumstances exist that the person did not anticipate at the time of the decision and which would have affected the decision had they been able to anticipate them.

A valid and applicable Advance Decision to refuse treatment for a mental disorder can be overruled if the person is detained under the Mental Health Act. Special provision applies to ECT.

If an AD is not valid or applicable, it should be considered as a written statement of the person's wishes and feelings.

Written Statements about Wishes and Feelings

People may make an advance statement about their preferred care or treatment for a future time when they may lack capacity to make that decision. However, such statements about preferred treatment are not binding in the same way as advance decisions to refuse treatment. It is not possible to make a binding advance decision to refuse care. Advance statements about care preferences including living arrangements must be considered as part of Best Interest decision-making. If a person has put their care preferences in writing, the decision maker must consider them carefully and record their reasons for not following the written wishes including the reasons why it was not in the person's Best Interest.

Decisions to refuse medical treatment for children and young people

The Mental Capacity Act applies to young people from the age of 16. The law does not provide for young people (until the age of 18) to make legally binding advance decisions to refuse medical treatment. If a young person (as any person), has capacity to decide whether to consent to treatment, they are entitled to refuse treatment. Parental consent should not be relied upon to overrule the refusal of a young person. The Mental Health Act or the Family Division of the High Court may provide legal recourse depending on the individual situation.

If a young person lacks capacity to make the decision, then a decision will need to be made in their best interest according to the principles of the Act. If the young person has recorded their wishes at a time when they had capacity, this should be treated as a written statement of wishes and feelings to be taken into account as part of any best interest decision. The Court of Protection can make declarations or orders in relation to the health, welfare, property or affairs of young people who lack mental capacity to make the relevant decision themselves.

In relation to children under the age of 16, consent should be considered in line with the guidance set out in Gillick v West Norfolk, 1984. Where a child is not Gillick competent, the consent of an adult with parental responsibility should be sought. Where the issue to be decided is outside the realm of parental responsibility, further lawful authority may be required. Where a child is Gillick competent, they are entitled to refuse treatment. Parental consent should not be relied upon to overrule the refusal of a child who is considered competent to make the relevant decision. The Mental Health Act or the Family Division of the High Court may provide legal recourse depending on the individual situation. If a child is refusing life-sustaining treatment, legal advice should be sought.

Enduring / Lasting Power of Attorney (LPA) and Court appointed deputies

A power of attorney is a person/s legally appointed (donee) by a person (donor) to make decisions on their behalf. There are several types of power of attorney. If a person claims to have power of attorney, it is important to ask what type they have and ask to see evidence of this.

Enduring Power of Attorney are those appointed before 2007 to make decisions about a donor's financial affairs. They can still be valid if registered with the office of the public guardian. They should be registered with the office of the public guardian when the person has lost or is losing mental capacity to make their own decisions about their financial affairs. They are not intended to be used while the person still has mental capacity to make their own decisions about their financial affairs. They do not give the attorney power to make decisions about health and welfare issues.

Lasting Power of Attorney (LPA) was introduced by the MCA and can be appointed while a person age 18 or over has mental capacity to do so. LPAs must also be registered with the office of the public guardian before it can be used. Lasting power of attorney can be in relation to property and affairs or health and welfare or both. Unless the donor states otherwise, a property and affairs LPA can be used (if registered) before the donor loses capacity for relevant decisions. A health and welfare LPA can only be used (if registered) at a time when the donor lacks capacity to make a specific decision. The donor may place restrictions on the scope of a health and welfare LPA especially in relation to life-sustaining treatment. A health

and welfare LPA cannot overrule an Advance Decision made by the person after they were appointed.

If a person no longer has mental capacity to appoint an LPA, the court can appoint a deputy to make decisions. These can be for individual decisions, property and affairs or health and welfare, subject to any limitations set by the court. Court appointed deputies are supervised by the office of the public guardian.

Where there is a power of attorney or court appointed deputy in place for the relevant decision, it will be for the attorney or deputy to determine what is in the person's best interest. LPAs should have regard to the code of practice and must act in the donor's best interest. They are able to give consent on behalf of the person in accordance with the type of power that they hold, and subject to any limits set by the donor. The consent has the same legal standing as if it was given by the person; however, they cannot consent to what would otherwise be a deprivation of liberty.

If anyone suspects that a power of attorney or deputy is misusing their power, they should follow safeguarding adult procedures. In addition to this, it may be appropriate to refer the matter to the Office of the Public Guardian. The public guardian can apply to the court of protection to remove an attorney or deputy.

Differences of opinion between professionals and an LPA or deputy about what is in the person's best interest will not always constitute a safeguarding concern. See also dispute about best interest decisions.

Making Best Interest Decisions

The Act provides protection from liability when providing care or treatment for a person who lacks capacity to consent as long as the person carrying out that care or treatment has a reasonable belief that the person lacks capacity to make the decision and a reasonable belief that the care or treatment is in the person's best interest. This can include acts that constitute restraint, so long as the action is the least restrictive intervention necessary to protect the person from harm and is proportionate to the risk of harm in type and duration. The code of practice defines restraint as the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist.

Working out what is in a person's best, must include consideration of the following:

- If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later.
- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour.

- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision.

- All relevant circumstances should be considered including:

    1. The person's past and present wishes and feelings (in particular, any relevant written statement made when s/he had capacity)

    2. the beliefs and values that would be likely to influence the person's decision if s/he had capacity,

    3. other factors that the person would be likely to consider if able to do so

    4. the views of:

        a. anyone named by the person as someone to be consulted
        b. anyone providing care for the person or interested in his/her welfare
        c. any court appointed deputy or power of attorney

        as to what would be in the person's best interest and, any information they can provide about points 1-3.

- Anyone who is deciding whether or not life-sustaining treatment is in the best interests of someone who lacks capacity to consent to or refuse the treatment must not be motivated by a desire to bring about the person's death.

The MCA cannot be used to take a decision for someone that a person with capacity could not take for themselves. In other words, best interest decisions are limited to options that a person would have if they could make the decision themselves.

A best interest decision should be recorded wherever consent would normally be required, but the person lacks mental capacity to give that consent. Records should include, at minimum, the following information:

- The decision to be made
- Reference to the assessment of capacity for that decision
- The views of the person
- Who was consulted and what were their views
- Other matters taken into account (see list above)
- What was decided
- If the decision is restrictive in any way, what other less restrictive options were considered and the basis on which they were ruled out.
- Whether anyone disagreed with the decision

Disputes about best interests

Anyone making a best interest decision should seek consensus with others involved in the care of the person. If there is disagreement, the code of practice suggests that holding a meeting or conference may be a useful. Meetings can allow family members to air conflicting views and promote multi-disciplinary discussion. It is not necessary to hold a meeting each time a best Interest decision needs to be made, but best practice guidance may suggest that meetings are preferable for certain decisions such as decisions about covert medication (see NICE guidance).

If there is still a disagreement after a meeting, an interim plan should be made. The person who disagrees should be given advice on how to challenge the decision. If the dispute is about admission to residential care or hospital, deprivation of liberty should be considered. The CCG may wish to take legal advice as to whether an application to the court of protection may be required in the circumstances.

If professionals disagree with the decision of an LPA or deputy, they should first discuss their concerns with LPA or deputy clearly setting out the reasons why they believe a different course of action would be in the person's best interest. They should also ask the LPA or deputy to explain the reasons for their own conclusion as to what would be best for the person in the circumstances. If the matter cannot be resolved through discussion, it may be appropriate to seek legal advice as to whether the CCG should make an application court of protection.

Independent Mental Capacity Advocates (IMCA)

An IMCA is a statutory advocate that must be involved in certain best interest decisions if there is no-one else willing or appropriate (on an un-paid basis) to be consulted as part of a best interest decision.

An IMCA must be involved in decisions about:

- serious medical treatment
- moving into a care for more than 28 days or in a hospital for 8 weeks
- during an assessment for deprivation of liberty safeguards authorisation

An IMCA may be involved:

- when care arrangements are being reviewed

Deciding whether a person's friends or family members are "appropriate to consult," involves considering whether there is any reason that speaking to them and seeking their views about the person would be harmful to the person. There is an expectation that friends and family members who are willing to be involved will be consulted as part of best interest decisions.

An IMCA would not usually be involved:

- merely because there is a dispute about what is in a person's best interests
- merely because there is a disagreement between family and professionals

An IMCA may be involved even when the person has family or friends:

- during a safeguarding investigation
- while a person is subject to a deprivation of liberty safeguards authorisation
- to assist a person appointed as a DoLS representative

An IMCA does not make the best interest decision. The professional making the best interest decision must take into account any information provided by the IMCA. An IMCA can take steps to challenge the decision on behalf of the person.

According to the code of practice, the MCA provides IMCAs with certain powers to enable them to carry out their duties. These include:

- the right to have an interview in private with the person

- the right to examine, and take copies of, any records that the person holding the record thinks are relevant to the decision (for example, clinical records, care plans, social care assessment documents or care home records).

The person responsible for making the relevant best interest decision should make a referral for an IMCA as soon as it becomes clear that one will be required. For deprivation of liberty safeguards, all IMCA referrals will be made by the relevant local authority. For any other IMCA referral, the relevant professional should contact the IMCA service in the area where the person is currently residing (including temporary hospital stays) regardless of ordinary residence.

The code of practice indicates, "the only situation in which the duty to instruct an IMCA need not be followed, is when an urgent decision is needed (for example, to save the person's life). This decision must be recorded with the reason for the non-referral. Responsible bodies will however still need to instruct an IMCA for any serious treatment that follows the emergency treatment. While a decision-maker is waiting for the IMCA's report, they must still act in the person's best interests (for example, to give treatment that stops the person's condition getting worse).

IMCA services are commissioned by local authorities to support anyone who is located within that geographical area. Any difficulties accessing IMCA services or the timeliness of response should be discussed with the MCA/DoL lead practitioner for NEW Devon CCG.

Deprivation of Liberty

Deprivation of Liberty is another term for detention or confinement. It does not refer to an individual restriction or incidence of restraint. In 2014, the UK Supreme Court clarified the definition of deprivation of liberty.

A person is deprived of their liberty if:

(1) the person is subject to continuous supervision and control

> If someone needs to know where the person is and what they are doing at all times for their own safety – this is considered continuous control.

And

(2) the person is not free to leave

> According to the 2015 Law Society guide to identifying a deprivation of liberty, if a person is not free to come and go as they wish (with or without help) save with the permission of the decision-makers around them, then they are probably not "free to leave." This is more concerned with the actions that would be taken if a person tried to leave than whether they are actually trying to leave.

And

(3) the person has not given valid consent to the arrangements.

> A person who lacks capacity to make a decision is not able to give valid consent.

This is sometimes known as the acid test.

The right to liberty is a basic human right. People may only be lawfully deprived of their liberty if a legal procedure is followed. The procedure must include the right of appeal to a court.

Best Interest decision-making under the MCA is not a sufficient procedure to provide lawful justification for a deprivation of liberty. Protection from liability under the Act does not extend to protection from liability for unlawful deprivation of liberty.

The Mental Health Act does contain procedures by which a person may be deprived of their liberty in order to receive treatment for a mental disorder.

The Deprivation of Liberty safeguards (DoLS) also provides a procedure by which a person who lacks capacity to consent to their care and treatment arrangements can be deprived of their liberty. This procedure can only be applied to people over age 18 in a registered care home or hospital.

Under the deprivation of liberty safeguards, it is the responsibility of the care home manager or hospital to apply for an authorisation from the relevant local authority.

If a professional believes a person in a hospital or care home is deprived of their liberty, they should discuss it with the care home manager/hospital ward manager. If

the care home/hospital agrees, they should make an application for an authorisation. If the care home/hospital does not agree to request a DoLS authorisation, the professional should approach the relevant local authority DoLS office to discuss the situation and report any un-authorised deprivation.

If a person is subject to a deprivation of liberty safeguards authorisation, the authorisation may have conditions. Any condition of a DoLS authorisation should form part of the person's care/treatment plan. If it considered unsafe or impossible to comply with the condition, the DoLS office who issued the authorisation should be informed immediately. The DoLS office should also be informed in the person's circumstances change so that the authorisation can be reviewed. Everyone subject to an authorisation will have a person appointed as their representative. The person's representative should be included in all decisions about the person's care and treatment. The person may also have an IMCA. An IMCA supporting a person subject to a DoLS authorisation has a specific role and may not become involved in all care and treatment decisions unless they are relevant to the deprivation of liberty. It may be best to contact the DoLS IMCA regarding any decisions about care or treatment and ask whether they would like to be involved in the discussion.

For anyone age 16 or over who lacks capacity to consent to their care arrangements but does not fall within the deprivation of liberty safeguards or the Mental Health Act, the appropriate procedure is to make an application to the court of protection. It is the responsibility of the public body funding the person's care or treatment to make the application to the court. If the person's care has been arranged privately, the local authority will be responsible to take steps to ensure that the procedure has been followed. The relevant local authority should be notified in writing.

If an employee of NEW Devon CCG identifies a person that is deprived of their liberty, they should take responsibility to formally notify the relevant authority.

Deprivation of Liberty for physical treatment in hospital

In the case of R (Ferreira) v HM coroner for inner south London [2015] EWHS 2990, the UK courts indicated that there is one situation where the definition of deprivation of liberty may be different to that given by the UK Supreme Court (above). This is in the context of a person who lacks capacity to consent to receiving treatment for a physical disorder in hospital. In this context only, the situation may not be considered a deprivation of liberty if:

- It is unavoidable as a result of circumstances beyond the control of professionals
- the treatment is necessary to avert a real risk of serious injury or damage
- the treatment is not materially different from that which would be given to a person of sound mind (according to medical evidence) in the same condition

If a person who lacks capacity to consent to their treatment and stay in hospital is or may be deprived of their liberty for a non-negligible period, it is the responsibility of the hospital to make an application for a DoLS authorisation to the local authority where the person is ordinarily resident. If the circumstances would amount to a deprivation of liberty under the usual definition, but the hospital decides that it is not necessary to make a DoLS application according to the above guidance, the hospital should keep a written record of its rationale for not making an application indicating how the guidance applies to the individual circumstances.

Deprivation of Liberty and end of life care

It has been suggested that it may not be necessary to follow deprivation of liberty safeguards procedures in relation to planned palliative care. If the person has capacity to consent to the anticipated care and treatment including any restrictions, then the provider may rely on the person's consent even if the person subsequently loses capacity to consent. The procedures would still need to be followed if the care and treatment changed from what was originally anticipated or the person objected to the arrangements when they no longer had mental capacity to refuse consent.

Appendix 2 Section 49 Guidance

1. Introduction

1.1 Section 49 of the Mental Capacity Act makes provision for the court to require a local authority, or an NHS body, to arrange for a report to be made by one of its officers or employees, or by such other person as the authority, or the NHS body, considers appropriate.

1.2 The court will usually request a report where it needs more information in order to make a decision. It will usually consider whether the public body has recent knowledge of P; or it is reasonably expected that they have recent knowledge of P; or should have knowledge due to their statutory responsibilities under housing, social and/or health care legislation; or the role of the public body is likely to be relevant to the decisions which the court will be asked to make. The court is not required to take into account the scare human or financial resources of the public body. The court will take into account representations by the public body in relation to scope and timetable for the report.

2. Contents

2. Purpose of the guidance

2.1 The purpose of this guidance is to clarify the responsibilities of Northern, Eastern and Western Devon Clinical Commissioning Group (the CCG) in relation to section 49 reports for the court of protection.

2.2 The policy should be read in conjunction with the MCA and DoL policy.

3. Roles and Responsibilities

3.1 The court rules and practice direction refer to a “senior officer” who can receive the court order on behalf of the organisation. In this context, the senior officer will be the chief nursing officer or another member of the executive team.

3.2 The “nominated person” is the person with appropriate experience/knowledge nominated by NEW Devon CCG to complete the report. This person may be employed by the CCG or be someone who has agreed to complete the report in accordance with the order on behalf of the CCG.

3.2 The designated MCA and deprivation of liberty safeguards lead practitioner will be responsible for liaising with the nominated person to verify that the report is to be completed within the timetable set out in the court direction and to seek any necessary legal advice on behalf of NEW Devon CCG in relation to the order. The nominated person may also seek legal advice as required.

3.3 Anyone working on behalf of the CCG who is contacted in relation to a section 49 report should immediately bring this to the attention of the designated MCA lead and the chief nursing officer or other member of the executive team.

4. Discussions in advance of an order

4.1 A pilot scheme which began in September 2016 aims to clarify the process for use of section 49 reports. It requires that – "Wherever practicable, before making an application for an order requiring a report under section 49, a party to proceedings should use their best endeavours to:

(a) make contact with an appropriate person within the relevant local authority or NHS body so they are made aware that an application is to be made; its purpose; and the issues or questions which are hoped to be addressed within the report;

(b) identify a named person or by reference to their office ("the senior officer") within the relevant local authority or NHS body who will be able to receive the court order on its behalf; and

(c) enquire as to the reasonableness and time scales for providing the report should the court order it.

4.2 Anyone within NEW Devon CCG who is approached in advance in accordance with this practice direction (pilot), should advise that the senior officer to receive the order is the Chief Nursing Officer.

4.3 The chief nursing officer, or anyone she may delegate, will consider the most appropriate person to nominate to complete the report and enquire of them as to the realistic timescales for providing the report.

4.4 If it is apparent that the most appropriate person to nominate to complete the report is an employee of another NHS body (rather than a CCG employee or another non-statutory health provider), the CCG may advise at part of this discussion that it may be more appropriate for the court to direct the enquiry and subsequent order to the relevant NHS body.

4.5 If an employee or officer of NEW Devon CCG is approached directly to complete a section 49 report, they should inform the chief nursing officer and the designated MCA lead of the request to confirm whether they are the most appropriate person to complete the report.

5. Receipt of an order

5.1 Where the court makes an order for a section 49 report, a copy of the approved order (which is binding, notwithstanding that it may not yet be sealed), the information described in paragraph 5.4 below and the accompanying letter of instruction will be served as soon as is reasonably practicable but in any event within 48 hours of the making of the order.

5.2 Upon receipt of the order the senior officer must ensure that—

(a) a person with appropriate expertise/knowledge is nominated to make the report; and

(b) the parties are notified of the name and contact details of the nominated person as soon as practicable.

5.3 The nomination should be made before the end of the period of 7 days beginning with the date on which the senior officer received a copy of the order.

5.4 The court will generally provide, or give permission to the party applying for the section 49 order to provide, to the person who is to produce a report— (a) a copy of the application form, its annexes and any supporting evidence as may be redacted by direction of the court; (b) the name and contact details of P; (c) the name and contact details of the parties; (d) the name and contact details of any legal representative of a person specified in (b) or (c); and (e) name and contact details of such other persons who are reasonably likely to be able to

provide assistance to the nominated person for the completion of the report. Where appropriate, the order may also allow P to be interviewed in private by the nominated person who is to prepare the section 49 report under arrangements made by the relevant local authority or NHS body.

6. Completing the report

6.1 The person required to prepare a section 49 report must produce it in accordance with the timetable set out in the court's directions.

6.2 Details of the contents of a section 49 report are set out in appendix 1

6.3 Where a report is made under section 49 the court may, on the application of any party, permit written questions relevant to the issues before the court to be put to the person by whom the report was made. The nominated person will be expected to provide answers to these questions in writing in accordance with the timetable provided by the court.

6.4 Where a nominated person has made a report, they should be aware that they may also be called as a witness.

7. Working with providers

7.1 Where the CCG believes that an employee of a provider service would be the most appropriate person to nominate to make a report, this will be done by agreement within existing contract and working arrangements.

7.2 Agreement to act as nominated person will include all functions in part 6 of this guidance and any other functions as may be required by the court.

8. Contents of the Report

It is the duty of the person who is required to make the report to help the court on the matters within his expertise.

Unless the court directs otherwise, the person making the report must— (a) contact or seek to interview such persons as he thinks appropriate or as the court directs; (b) to the extent that it is practicable and appropriate to do so, ascertain what P's wishes and feelings are, and the beliefs and values that would be likely to influence P if he had the capacity to make a decision in relation to the matter to which the application relates; (c) describe P's circumstances; and (d) address such other matters as are required in a practice direction or as the court may direct.

The report should contain four main sections. These are—

1. the details of the person who prepared the report;
2. the details of P;
3. the matters and material considered in preparing the report; and
4. the conclusions reached.

In the **first section** (details of the person who prepared the report), the report should—
(a) state the full name of the person who prepared the report;
(b) state whether that person was appointed under section 49(2) or (3) of the Act;
(c) state whether that person is an officer, employee or other person nominated by a local authority; or an officer, employee, or other person nominated by an NHS body;

(d) state that person's occupation or employment (for example, social worker employed by a local authority or general practitioner in private practice); and
(e) list that person's qualifications and experience.

In the **second section** (P's details), the report should (unless an order to the contrary pursuant to rule 19**6** has been made)—

(a) state P's full name, date of birth and present place of residence;

(b) state P's nationality, racial origin, cultural background and religious persuasion (if appropriate);
(c) identify P's immediate family (specifying their relationship to P and contact details;
(d) identify any other person who has a significant role in P's life (for example, a close friend or a carer) specifying their role and contact details; and
(e) give a summary of P's medical history.

In the **third section** (matters and material considered), the report should—
(a) list any interview conducted with P (specifying time and place);
(b) list any interview conducted with one or more persons other than P (specifying time and place);

(c) state—
(ii) the name and qualifications of any person who assisted with any such examination;
(d) give a summary of any key events in P's life which appear to have a direct bearing on the matters to be dealt with in the report;
(e) set out the details of any of the following material which was relied on in the preparation of the report—
(i) any literature or other material;
(ii) any records obtained under section 49(7) of the Act;

(f) set out the details of facts and opinions relied on in the preparation of the report (ensuring that there is a clear distinction between the two);

The person preparing the report should ensure that any notes made during the interview with P or any person other than P are kept so that the notes are available for production to the court if necessary.

(g) where there is a range of opinion on an issue addressed in the report—
(i) summarise the range of opinion,

(ii) state the views held by the person who prepared the report and give reasons for them; and

(h) indicate which of the facts are within the knowledge of the person who prepared the report.

In the **fourth section** (conclusions), the report should—

(a) identify any issues or questions which were specified in the directions given by the court as being matters in which the court had a particular interest;

(b) address clearly such issues or questions;

(c) state clearly all conclusions reached by the person who prepared the report;

(d) state clearly the recommendations made by the person who prepared the report; and

(e) contain a statement of truth in the following terms—

"I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are, and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion."

Appendix 3 Community DoL checklist

This checklist should be used for anyone age 18 or over in any setting ***other than care homes or hospitals*** and anyone age 16 or 17 in ***any*** setting.

☐ The person lacks mental capacity to consent to their care and living arrangements

Does the person have an impairment of the mind or brain?

Does the impairment cause an inability to understand salient information relevant to the decision, retain the information for long enough to make the decision, weigh and use the information to reach a decision or communicate the decision (in any way)? This should be concluded on balance of probabilities.

☐ The person is not free to leave

Consider what actions would be taken if the person tried to leave? (also consider, if relevant, whether the person would be allowed to live elsewhere) If a person is not free to come and go as they wish (with or without help) save with the permission of the decision-makers around them, then they are probably not "free to leave."[1] This is not based on physical ability.

☐ The person is under continuous supervision and control

Do carers need to know where the person is and what they are doing at all times for their own safety – this is considered continuous control. Consider what other restrictive measures are in place affecting the person's freedom of movement.

☐ The restrictions are necessary and proportionate AND the least restrictive option available to keep the person safe? If not, formally review care plan.

Notify the commissioning authority that the person is deprived of their liberty. If it is a private arrangement, notify the local authority (social care) in the area.

At the same time, notify the commissioning authority if any of the following apply:

- The person is objecting to any part of their care or treatment (including acting in a way that could be interpreted as an objection to the arrangements)
- Family or friends disagree with any part of the person's care or treatment

The views of family or friends have not been taken into account in the care planning process for any reason (including any safeguarding concerns)

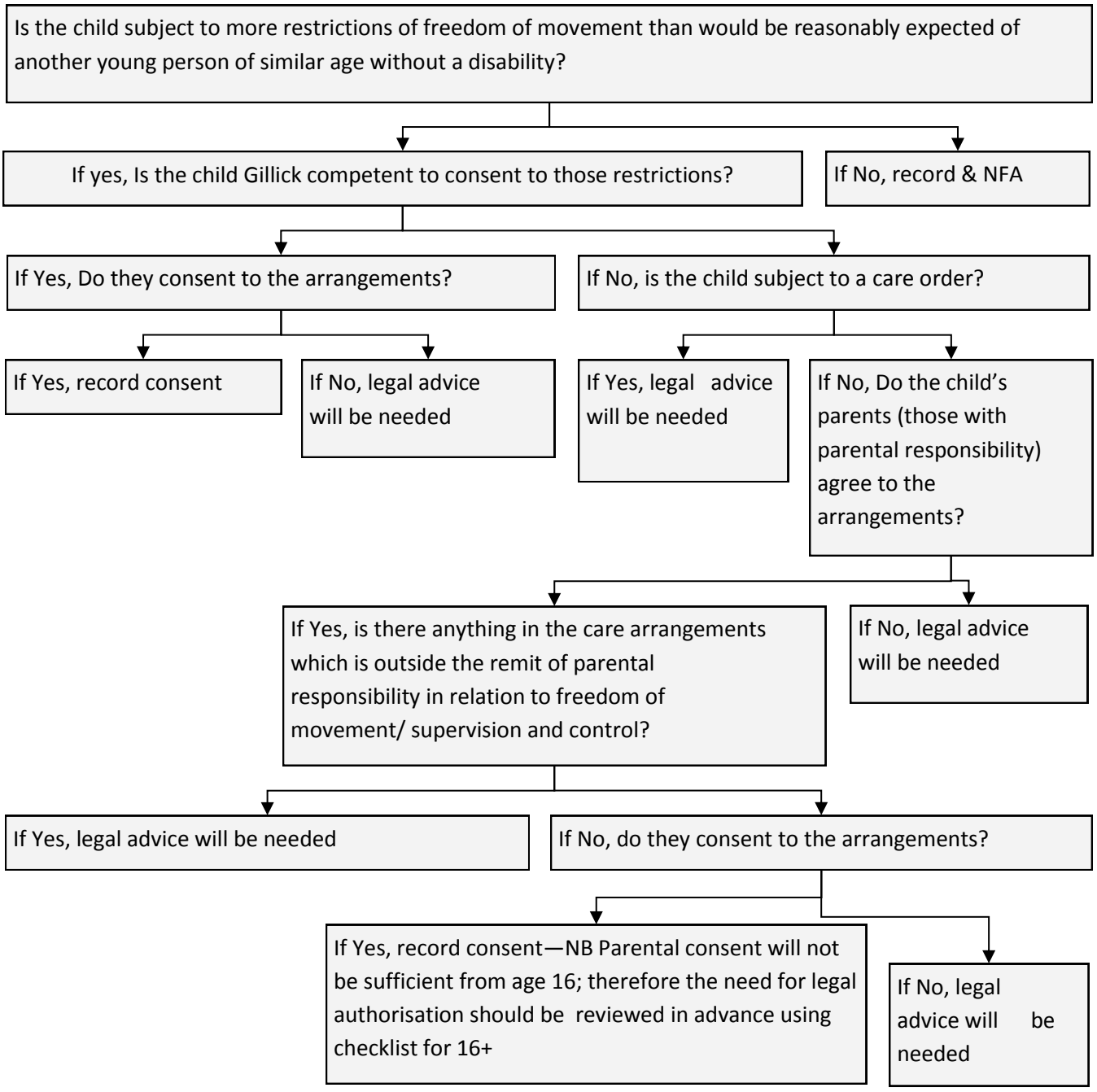
[1] Law Society practical guide to identifying a deprivation of liberty © 2015 The Law Society.

Appendix 4 Deprivation of Liberty for under 16s

Deprivation of Liberty for under 16s

This chart is designed to consider whether additional legal authorisation is required.

If there are concerns that restrictions are not necessary or proportionate in the circumstances, the care plan should be formally reviewed prior to consideration of any legal authorisation. Authorisation will usually be via the high court function of the family courts.



Deprivation of Liberty for under 16s checklist

This checklist is designed to consider whether legal authorisation is required for any deprivation of liberty in addition to the consent of the child or parental consent. Before proceeding with this checklist, it should be agreed by all parties that any restrictions are necessary and proportionate in the circumstances.

☐ The child is not Gillick competent in relation to care and treatment

"...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent." (Gillick v West Norfolk, 1984)

For further information: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

☐ The child is deprived of their liberty

Is the child subject to more restriction of freedom of movement than would be reasonably expected for another young person of similar age without a disability? Consider the child's freedom to come and go without supervision, the levels of supervision and other restrictive measures that are in place affecting their freedom of movement (e.g. restraint or seclusion) and how these affect the child's autonomy.

If both of the above apply, it is important to record the consent of the child's parents (those with parental responsibility) to the arrangements.

Legal advice should be sought if:

- those with parental responsibility do not agree to the arrangements
- the child objects to the arrangements (regardless of competence to consent)
- there is anything in the arrangements outside the remit of parental responsibility
- the child is subject to a care order (full or interim, not section 20)

Where there is a deprivation of liberty which requires legal authorisation, the lead commissioner for the arrangements should be formally notified in writing.

Appendix 5 Useful Links and supporting information

Mental Capacity Act
http://www.legislation.gov.uk/ukpga/2005/9/contents

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

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

Mental Capacity Act 2005: A guide for clinical commissioning groups and other commissioners of healthcare services on Commissioning for Compliance
https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf

Mental Capacity Law: A brief guide to carrying out capacity assessments
http://www.39essex.com/content/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf

Mental Capacity Law: A brief guide to carrying out best interests assessments
http://www.39essex.com/content/wp-content/uploads/2016/08/Best-Interests-Assessments-Guide-August-2016.pdf

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

Court of Protection
https://www.gov.uk/court-of-protection

Court of Protection judgments
www.bailii.org/ew/cases/EWHC/COP/

Court of Protection Rules
https://www.judiciary.gov.uk/publications/court-of-protection-amendment-rules-2017/

Practice Direction 14E (pilot)
https://www.judiciary.gov.uk/wp-content/uploads/2016/03/cop-14e-pilot-june2016l.pdf

Court of Protection judgment relating to section 49 reports
http://www.39essex.com/cop_cases/rs-v-lcc-ors/

Social Care Institute for Excellence MCA directory
http://www.scie.org.uk/mca-directory

Lasting Power of Attorney

https://www.gov.uk/make-decisions-for-someone

Advance Decisions
http://compassionindying.org.uk/library/healthcare-professionals-toolkit/

Right of children to refuse medical treatment
GMC http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_30_33_refuse_treatment.asp

BMA https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/children-and-young-peoples-ethics-tool-kit/4-consent-and-refusal

Independent Mental Capacity Advocates
Plymouth http://www.plymouthhighburytrust.org.uk/advocacy/imca/
Devon http://www.ageuk.org.uk/devon/our-services/imca/

Deprivation of Liberty Safeguards offices
Plymouth http://plysab.proceduresonline.com/chapters/pr_contacts.html#dols_office
Devon http://www.devon.gov.uk/mca-deprivation-of-liberty-policy.pdf

Appendix 6 Glossary

Advance decisions

A decision to refuse specified treatment made in advance by a person aged 18 or over who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment.[2]

Court of Protection

The specialist Court for all issues relating to people who lack capacity to make specific decisions.[1]

Impairment of the Mind or Brain

an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works, the impairment or disturbance does not have to be permanent. Examples include: conditions associated with some forms of mental illness, dementia, significant learning disabilities, the long-term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion following a head injury and the symptoms of alcohol or drug use. [1]

Independent Mental Capacity Advocates (IMCAs)

Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. [1]

P

Used by the court of protection to denote the person about whom decisions are being made, the subject of the proceedings.

Parties

Those listed as officially involved in the proceedings.

[2] MCA code of Practice © Crown Copyright 2007