MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

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Author(s)	Designated Nurse for Adult Safeguarding
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HISTORY OF CHANGES		
Old version number	**Significant changes**	**New version number**
1	Contact Information – once official statutory guidance is published for the MCA Amendment Act (2019) this policy will require a complete re-write.	1.2
1.2	Updated following amendments made to the Mental Capacity Act relating to Liberty Protection Safeguards (LPS) which were set to replace Deprivation of Liberty Safeguards. The implementation of this however has been paused indefinitely and the policy will therefore need reviewing again if LPS is enacted.	2

Impact Assessments – available on request		**Impact Assessments – available on request**	
	Stage	Complete	Comments
Equality Impact Assessment	1	14/08/24	
Quality Impact Assessment			N/A
Privacy Impact Assessment			N/A

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1.0 PURPOSE AND INTRODUCTION

1.1 The purpose of this policy is to support the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) to discharge their duty of ensuring commissioned services are compliant with the Mental Capacity Act (MCA) amendment act 2019 and Deprivation of Liberty Safeguards (DoLS) 2009 as outlined within the NHS England (2014) guide for ICBs.

1.2 The MCA promotes the empowerment of individuals to make decisions for themselves as far as is possible and protects vulnerable adults who may lack capacity to make their own decisions. The MCA provides a framework for protecting people who may be unable to make decisions for themselves and for those who wish to plan for a time when they may lack capacity to make certain decisions. The MCA is built on five statutory principles that guide and inform decision-making when working with people who may lack capacity for making choices in some aspects of their life including their health care. The underlying philosophy is that any decision made, or action taken must be made in the best interests of someone who lacks the capacity to make the decision or act for themselves.

1.3 The DoLS framework applies to people aged 18 or over and the purpose is to prevent arbitrary decisions that deprive people who lack capacity of their liberty. Under the framework, people can be deprived of their liberty in hospitals, care homes for the purposes of care and treatment. For supported living environment adult placements and small homes an application for DOLs must be made to the Court of protection

1.4 The two codes of Practice for MCA and DoLS have statutory force meaning that there is a legal duty for certain people, including those providing health care, to have regard to the codes when appropriate.

Mental Capacity Act 2005 Code of Practice, including the Liberty Protection Safeguards (publishing.service.gov.uk)

https://www.health-ni.gov.uk/sites/default/files/publications/health/mca-dols-cop-november-2019.pdf

1.5 NHS commissioners require a good understanding of both MCA, and DoLS so they can ensure that assessments of capacity are carried out appropriately, that decisions made on behalf of people who lack capacity are made in their best interests and that any deprivation of liberty is prescribed and monitored appropriately and with due process.

2.0 SCOPE

2.1 This policy aims to ensure that no act or omission by the ICB as a commissioning organisation puts an adult who lacks mental capacity at risk by ensuring robust systems are in place to safeguard and promote the rights of adults without capacity in commissioned services.

2.2 This policy applies to all staff (temporary and permanent) directly employed by the ICB involved in the commissioning of services to provide guidance for ensuring that all commissioned services comply with MCA and DoLS legislation.

2.3 The policy does not set out to provide a detailed account of the MCA, and DoLS but seeks to provide a process for ensuring the ICB and its employees seek adequate assurances from service providers in their duty to deliver on the requirements of the Act.

3.0 DEFINITIONS

3.1 **Advance Decision**: This is a decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision.

3.2 **Best Interests**: Any act done, or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the Mental Capacity Act sets out a non-exhaustive checklist.

3.3 **Best Interests Assessor:** Best Interests Assessors (BIAs) are authorised practitioners who complete Best Interests Assessments in accordance with the MCA who have undertaken further and continuous training to maintain their competence.

3.4 **Court of Protection:** The Mental Capacity Act created this court which has jurisdiction relating to the whole of the Act.

3.5 **Decision Maker**: This is a person who is responsible for deciding what is in the Best Interests of a person who lacks capacity which can be a professional, family member, carer or close friend dependent upon the decision needing to be made.

3.6 **Deprivation of Liberty**: This is a term used in the European Convention on Human Rights about circumstances when a person lacking capacity is deprived of their liberty. There is no simple definition of deprivation of liberty. See Chapter 2 of the DoLS Code of Practice for a more detailed understanding. Case law constantly changes and informs practice relating to deprivation of liberty.

3.7 **Independent Mental Capacity Advocate (IMCA)**: This is a person who supports and represents a person who lacks capacity and where that person only has paid staff to support them. An IMCA must be instructed for serious medical decisions, accommodation changes and where there are safeguarding adult concerns and in some DoLS cases.

3.8 **Lasting Power of Attorney (LPA)**: This is a power of attorney created under the Mental Capacity Act 2005. It enables a person (the donor) with capacity to appoint another person to act on their behalf (the done) in relation to decisions about the donor's financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used.

3.9 **Managing Authority**: The person or body with management responsibility for the hospital or care facility in which a person is or may become deprived of their liberty.

3.10 **Mental Capacity**: This describes a person's ability to make a specific decision at a specific time. A legal definition is contained in Section 2 of the Mental Capacity Act.

3.11 **Restriction/Restraint:** The MCA defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Section 6 of the Mental Capacity Act sets out limitations on the use of restraint when taking action in connection with care and treatment. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm.

3.12 **Supervisory Body**: A local authority, that is responsible for considering deprivation of liberty requests, commissioning the assessments, and where all the assessments agree, authorising deprivation of liberty.

3.13 **Office of the Public Guardian:** The Office of the Public Guardian is a government body that polices the activities of deputies, attorneys and guardians who act on behalf of people who lack the mental capacity for making decisions about finances, health and welfare.

4.0 ROLES AND RESPONSIBILITIES

4.1 The Accountable Officers of the ICB have overall responsibility for ensuring that the duties related to MCA and DOLS are effectively implemented across the local health economy through the ICB commissioning arrangements. Within the ICB this role is supported through the Chief Nurses and the Nominated MCA Lead.

4.2 The Chief Nurse/Clinical Lead for Quality for the ICB will be responsible through delegated authority, for assuring the Governing Body in respect of all issues relating to the implementation of the requirements of both MCA and DoLS.

4.3 The Designated Nurse for Adult Safeguarding as Nominated Lead for MCA should provide regular updates to the System Quality & Safety Committee and is responsible for ensuring policy development and compliance. The MCA Lead will be responsible for ensuring appropriate staff have access to training that is compliant with requirements agreed by the Staffordshire and Stoke-on-Trent Safeguarding Adult Partnership Board and the intercollegiate document (2018).

4.4 All Staff, where applicable will have a responsibility to ensure that MCA and DoLS is included in commissioning process/contracts and to undertake training, including attending regular updates so that they maintain their skills and are familiar with the legal requirements of the Mental Capacity Act.

4.5 All staff having contact with patient groups to be aware of principles of confidentiality and information sharing in line with the Mental Capacity Act.

4.6 All staff contribute, when requested to do so, to the multi-agency best interest meetings when related to commissioning of placements or packages of care.

5.0 PRINCIPLES OF THE MENTAL CAPACITY (Amendment) ACT 2019 (MCA)

5.1 The MCA is underpinned by 5 key principles that put the person at the centre of decision making and provides a framework for staff when providing care and treatment:

- A person must be assumed to have capacity unless it is established that he/she lacks capacity.
- A person must not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
- Any action taken, or any decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
- Before any action is taken, or any decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person.

5.2 The MCA makes provision for adults (aged 18 or over) to prepare for such times as when they may lack capacity, this could be the individual appointing an attorney to take decisions in relation to property and affairs and/or health and welfare and making advanced decisions to refuse treatments. An individual can be appointed by the court for this purpose, known as a deputy.

5.3 IMCA's must be instructed for serious medical decisions, accommodation changes and where there are safeguarding adults concerns where the adult lacks capacity to make the decision themselves and have no one to act as a representative. IMCAs should also be instructed where there are any concerns that the patient's representative is not acting in their best interests or if a Dols is being applied for and the patient representative would like the support of an IMCA.

5.4 Section 44 of the Mental Capacity Act introduced a criminal offence for ill treatment or neglect. Where a safeguarding concern indicates that this offence has occurred, this will be considered for investigation by the Police. Staff should seek advice from the ICB safeguarding team if support is needed with identifying and reporting such a concern. In an emergency 999 should be contacted.

6.0 DEPRIVATION OF LIBERTY SAFEGUARDS

6.1 The DoLS legislation came into force in April 2009 to prevent arbitrary decisions being made for persons who lack capacity to consent to care or treatment while in Hospital and Care Homes. Care and treatment should always be delivered in the least restrictive way possible however where it is thought necessary and in the best interests of a person to deprive them of their liberty applications must be made to the supervisory body.

6.2 Where a person resides in a supported living environment and a deprivation of liberty is identified and determined to be in their best interests, an application to the Court of Protection will be required. The ICB will be the organisation who must make an application to the Court of Protection where the person's care is being fully funding by through continuing health care funding.

6.3 Where individuals living in their own homes may be being deprived of their liberty a personal welfare declaration by the Court of Protection under s16 Mental Capacity Act will be required.

6.4 The Supreme Court ruling on 19th March 2014 in "P v Cheshire West and Chester Council and another" set out the *acid test* with the following key questions to determine whether a person is being deprived of their liberty.

Is the person free to leave (whether they are concordant or not)?
AND
Is the person subject to continuous supervision and control?

6.5 Legal support in making any applications to the Court of Protection will be available following ICB protocol.

6.6 Where a 16- or 17-year-old lacks capacity to consent themselves to arrangements which meet the acid test for deprivation of liberty, a court authorisation will need to be sought.

7.0 GOVERNANCE

7.1 The ICB will apply the principles of sound clinical and corporate governance in relation to MCA and DoLS which takes into account the corporate governance framework for NHS organisations.

7.2 The MCA Lead will provide regular updates and reports to the Chief Nurse and to the System Quality and Safety Committee to include data and information regarding compliance to MCA as required.

8.0 CONTRACT

8.1 The ICB will ensure that requirements of the MCA and DoLS legislation is included within all commissioned services through inclusion in NHS Contracts.

8.2 Commissioned services will provide quarterly data through information reporting requirements within the adult safeguarding dashboard as requested. Any breaches of contract or issues relating to a provider's application of the Mental Capacity Act will be monitored and dealt with through usual contractual processes with support and advice from the ICB safeguarding team.

9.0 ICB RESPONSIBILITIES

In order to discharge their responsibilities with respect to the Mental Capacity Act the ICB will:

9.1 Identify a named MCA Lead to be accountable for ensuring that relevant policy, procedure, and organisational structures support their role.

9.2 Provide mandatory training for relevant ICB staff on the MCA to ensure they are aware of their responsibilities for its effective implementation as a key priority within strategic planning processes.

9.3 Ensure that all contracts for the delivery of health care promote best practice and include clear standards for implementing the MCA, DoLS specifying compliance.

9.4 Ensure that all health providers from whom services are commissioned have a comprehensive policy and procedure for MCA/DOLS including auditing of standards thereby providing assurance that the legislation is being correctly implemented. In addition, MCA/DoLS is included in other key policies e.g., Safeguarding, Consent, Restraint and Advanced Decision making.

9.5 Work with Staffordshire & Stoke-on-Trent Safeguarding Adults Partnership Board (SSASPB) and Board sub-groups to provide joint strategic leadership on MCA, and DoLS

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

10.0 TRAINING

10.1 The ICB will enable employed staff (temporary and permanent) to participate in MCA and DoLS training relevant and proportionate to their role to meet the requirements of commissioning of services.

10.2 Ensure that leads for safeguarding adults and mental capacity within the ICB have broad knowledge of healthcare for older people, people with dementia, people with learning disabilities, and people with Mental health problems.

10.3 The ICB will seek assurance from providers on compliance for staff training and induction in relation to MCA and DOLS/ in line with the standard NHS contract.

10.4 The ICB will seek assurance that any Best Interests Assessors who may be employed by them maintain their competence and registration in accordance with the requirements of the Mental Capacity Act.

11.0 MONITORING AND EVALUATION

11.1 In order to ensure that local guidance is followed effectively across the ICS the System Quality and Safety Committee will be responsible for maintaining on-going systems of audit and monitoring.

12.0 REVIEW

12.1 This policy will be reviewed every 2 years, and in accordance with the following as and when required:

- Legislative changes
- Good practice guidance
- Case law
- Serious incidents
- Safeguarding Adults Reviews (where applicable)
- Changes to organisational infrastructure

13.0 INTERNAL AND EXTERNAL REFERENCES

13.1 In developing this policy, account has been taken of the following statutory and non-statutory guidance:

Safeguarding Accountability and Assurance Framework NHSE 2022
https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf

NHS England (2014) Mental Capacity Act - A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance.
guide-for-clinical-commissioning.pdf (england.nhs.uk)

Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to Supplement Mental Capacity Act 2005. London. TSO
[ARCHIVED CONTENT] (nationalarchives.gov.uk)

Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. London. TSO
Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

Staffordshire & Stoke-on-Trent ICB Safeguarding Adults Policies can be found at the relevant ICB internal websites.

14.0 APPENDICES

Appendix 1 - Mental Capacity Act: Training Requirements within Services Commissioned by Staffordshire & Stoke-on-Trent ICB

The Mental Capacity (Amendment) Act (2019) provides a legal framework for making decisions on behalf of, and acting on those decisions for, individuals who lack capacity to make a particular decision for themselves. By following the Mental Capacity Act health professionals can provide care and treatment to those patients/clients who lack capacity to consent if the treatment decision can be evidenced as to be in the best interests of the patient/client at that specific time. All staff who provide care and/or treatment to patients/clients who may lack capacity to consent need to be able to competently complete an assessment of capacity using the two-stage process (stage two having four sub parts), and evidence through their record keeping the best interests decision, highlighting how the decision was made and actioned. There is a statutory obligation to refer a person who meets the criteria to the Independent Mental Capacity Advocacy (IMCA) service, and to have a full understanding of the Act and have regard to the accompanying codes of practice.

Training Responsibilities
Each individual health organisation will have responsibility to provide additional awareness sessions to meet the need of the staff population, and to finance and deliver MCA training at induction, level 2 and bespoke level to meet the staff requirements.

Model for the delivery of Mental Capacity Act Training
Provider services will be expected to demonstrate how they discharge their training duties by maintaining statistics of numbers of staff who have received each level of training. This will inform the commissioning, contracting and contract review process and will support the provider in demonstrating evidence for the Care Quality Commission and Monitor (for Foundation Trusts).