with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL POLICY
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

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Policy	*A Reference Number will be issued and added by Clinical Policy Group*
Version:	1.0
Purpose:	Policy to formalise processes and compliance in relation to the implementation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards
Consultation:	[redacted] Lead Nurse for Adult Safeguarding, Charlotte Jerram Legal Services Officer.
Approved by:	*The Committee / Group / Director that has approved this document (For Clinical Policies this needs to include approval though the Clinical Policy Group)*
Date approved:	*Date will be added after approval by Clinical Policy Group*
Author / Reviewer:	[redacted] MCA Lead and [redacted] MCA lead
Date issued:	*Date will be added on date of upload*
Review date:	*Date will be added after approval - Date by which the document should be reviewed, and a new version produced - normally every 3 years to ensure that it is contemporaneous to modern practice and research. All policies are subject to earlier review if significant changes in legislation or national best practice indicates*
Audience:	All Trust staff.
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin. It will also be included on the MCA pages of the Safeguarding section on the Intranet
Impact Assessments: *Help?*	*An Equality Impact Assessment needs to be completed for all Clinical Policies, Guidelines etc, this will determine whether a Quality Impact Assessment (QIA) is also required.*

Version History

Version	Date Issued	Reason for Change
V1	*Upload date will be added here*	New Policy

PART 1

SUMMARY

This policy is designed to ensure staff:

- Are aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005).
- That they have access to the information and processes they need to identify when a mental capacity assessment is required and when best interest decisions are needed in relation to those who are deemed to lack capacity.

The Policy will also outline the requirements for the organisation and staff in relation to the implementation of Deprivation of Liberty Safeguards (DoLS)

The policy will also provide staff with the information they need to enable them to support patients, carers and family members, to understand how the MCA 2005 and DoLS may relate to them and how it may impact them in the future.

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ABBREVIATIONS

Abbreviation	*Full Description*
GHC	Gloucestershire Health and Care NHS Foundation Trust
MCA	Mental Capacity Act
SMT	Serious Medical Treatment
S42 enquiry	Adult Safeguarding enquiry under section 42 of the Care Act 2014
DoLS	Deprivation of Liberty Safeguards
CoPDoLO	Court of Protection Deprivation of Liberty Order
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
LPA	Lasting Power of Attorney
OPG	Office of the Public Guardian
AD	Advance Decision
CoP	Court of Protection
CoPr	Code of Practice
IMCA	Independent Mental Capacity Advocate
RPR	Relevant Persons Representative
MHA	Mental Health Act
CTO	Community Treatment Order
GO	Guardianship Order

PART 2

This part should set out the detailed requirements and provisions of the document and should include the following sections. Sections should be sequentially numbered.

Action Cards should be inserted before the Introduction if to be included with a Policy – an action card template is available on request. If unable to insert these, please send separately to the Policy and Admin will add these at your request.

1. INTRODUCTION

1.1 The Mental Capacity Act (MCA) 2005 provides a statutory and quality framework to empower and protect people over the age of 16 who lack capacity to make decisions for themselves. It makes it clear who can take decisions, in which situations and how they should go about this in respect of people who lack capacity to make particular decisions for themselves.

1.2 The Act enshrines in statute principles concerning people who lack mental capacity and those who take decisions on their behalf. It puts a legal and statutory framework for decisions around capacity and Best Interests providing legal protection for staff and others, and protection for people who lack capacity by setting out a mandatory procedure for making decisions on their behalf. It provides three fundamental powers in relation to health and social care decisions;

- an opportunity for people who have capacity to plan for a time when they may lack capacity (Lasting Power of Attorney - LPA)
- a legal framework for people with capacity to record their wishes for future treatment, especially the refusal of treatment (Advance Decision - AD) and
- a legal framework for staff and others to make a Best Interests decision on behalf of another person.

1.3 Amendments to the Act in 2007 provide a legal framework whereby care arrangements which amount to a deprivation of liberty can be scrutinised and where appropriate authorised under the Deprivation of Liberty Safeguards (DoLS). It also provides access to appeal through the Court of Protection (CoP). This makes UK law compliant with Article 5 of the European Convention on Human Rights (ECHR)

2. PURPOSE

2.1 The purpose of this Policy is to ensure that :-

- Staff are aware of and meet their legal responsibilities under the MCA 2005 and the Deprivation of Liberty Safeguards.
- Staff have access to information and resources in relation to how to implement aspects of the MCA 2005 and DoLS, where they are relevant to patient care.
- Staff are able to provide support and information to patients, carers and family members in relation to the MCA 2005 and DoLS
- Patients under the care of the Trust receive the protection that the legal framework of the MCA 2005 and DoLS provide

A brief explanation of what the document is intended to achieve

3. SCOPE

3.1 This policy applies to all health and social care staff working within Gloucestershire Health and Care NHS Foundation Trust.

3.2 This Policy must be applied to all users of Trust services aged 16 and above, although there are some exceptions under the act in relation to people aged 16 and 17. These will be outlined below.

3.3 This Policy should be used in conjunction with other relevant Trust policies.

4. DUTIES

4.1 General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent, complies with the Mental Capacity Act (2005)

5. POLICY DETAIL

5.1 The 5 Principles of the MCA 2005

Staff must be aware and mindful of the 5 principles that underpin the legal requirements of the MCA. The 5 principles are summarised below:-

- A person must be assumed to have capacity unless it is established that they lack capacity.

- A person is not to be treated as unable to make a decision unless all practicable (doable) steps to help them to do so have been taken without success.

- A person is not to be treated as unable to make a decision merely because they make an unwise decision.

- Any action done or decision made, under this Act, for or on behalf of a person who lacks capacity, must be done, or made, in their best interests.

- Before the action 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 least restrictive of the person's rights and freedom of action.

5.2 What is mental Capacity?

Mental Capacity is the ability to make a decision in relation to a specific decision at a particular time**.**

The MCA 2005 defines a lack of capacity to make a decision as follows:-

"*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of a an impairment of, or a disturbance in the functioning of the mind or brain."* [MCA 2005 S2 (1)]

Mental capacity is time and decision specific. An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

5.3 When to assess mental capacity

Before considering whether a person's capacity in relation to a specific decision requires assessment, there must be some reason to trigger the view that capacity is in question. The first principle of the MCA is to assume that a person has capacity. It is for an assessor to evidence why capacity is in question. While the MCA requires that a lack of capacity cannot be assumed because of a person's age, illness or appearance, changes in behaviours may lead you to consider whether capacity is in question.

There are a number of reasons why people may question a person's capacity to make a specific decision:

- the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision

- somebody else says they are concerned about the person's capacity, or

- the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.

If mental capacity to make a specific decision is in doubt, then a formal mental capacity assessment in relation to that decision must be undertaken. (MCA CoPr 4.4).

5.4 Identifying what decision needs to be made

When assessing mental capacity to make a specific decision the assessor must be clear what decision they are assessing capacity for and must record this on the Truts formal mental capacity assessment document.

There is a distinction between day-to-day decisions and significant decisions. Day-to-day decisions can be broadly grouped within provision of health and social care within the following headings:

- Personal care needs
- Social needs
- Nutritional needs
- Safety needs
- Treatment needs
- Everyday finances.

A significant decision is being made if there are concerns that an individual may not have the capacity to:

- Consent to 'Serious Medical Treatment' (see Section 6.15 – 6.19, MCA 2005 CoPr). Real examples of SMT include 'smear tests', hip replacements/resurfacing, any treatment requiring a general anaesthetic, someone with breast cancer refusing treatment, blood test with serious implications, operation for a cataract etc.
- Changes to medication
- Use of covert medication and or chemical restraint
- Consent to an informal admission (to hospital, nursing or care home)
- Consent to a change of accommodation
- Manage their property or financial affairs, health or welfare
- Consent to their confidentiality being breached – e.g. during a S42 enquiry
- Make complex safety decisions e.g. GPS tracking devices
- Participation in court proceedings e.g. Family Court, High Court, whether as an individual or a parent

The above list is not exhaustive and professional judgement must be used

5.5 Provision of the Relevant Information

Before starting to assess if someone has capacity to make a specific decision, the information that a person would require to make that decision, must be identified and shared with the person. This is referred to as the 'relevant information'. Anyone, no matter what their capability to make a decision, requires access to the relevant information to be able to make an informed decision or give informed consent. Therefore when preparing to undertake an assessment of capacity practitioners must identify the relevant information relating to the decision and provide that information to the person, whose capacity is in question. The information must be provided in a way that they are most likely to be able to understand.

The relevant information may be provided in a range of ways that could include the following:-

- Verbally, in simple language that avoids jargon
- In writing including where appropriate in easy read format
- Through use of sign language
- Through use of a translator
- Through use of a picture board

It is important that when considering undertaking a capacity assessment that practitioners consider the communication needs of the person they intend to assess, not just to ensure relevant information is given in a way that they are most likely to understand, but so they have a better opportunity to engage in the assessment process.

Failure to provide all the relevant information, including information about risks, even when a person has capacity, may result in legal challenge such as in the case of Montgomery v Lanarkshire Health Board [2025] UKSC 11

When completing a formal mental capacity assessment form practitioners must outline, on the appropriate section of the form, what the relevant information is and how they have provided that information to the person.

Practitioners can access guidance about relevant information for a range of commonly used areas of decision making on the MCA pages on the Trust Intranet:- Uploader.ashx

5.6 Who Should assess?

The MCA stipulates that the person who assesses capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. A decision regarding a medical treatment will be for the medical professional, e.g. GP or consultant, to take. A decision on a care placement will be for social work professionals to take. It is important to remember professionals working with a person, with expertise in that particular area should not expect other professionals to assess capacity for that particular decision.

Family members and informal carers may be responsible for assessing capacity when a decision needs to be made about day-to-day care, such as what clothes to wear on a

particular day. The MCA does not require family members and informal carers who provide day-to-day care to undertake a formal capacity assessment each time they deliver care. Instead, they need to have 'reasonable belief' that the person lacks capacity for the specific decision.

For practitioners employed by the Trust, they should record the capacity assessment on the Trust mental capacity assessment form and save it in the person's records. The more complex the decision, the greater the expectation is for more robust recording of the capacity assessment. Practitioners are responsible for assessing capacity for actions they are proposing. This means, for example, that a nurse will be responsible for assessing a person's capacity to consent if they are proposing a particular treatment or intervention, and a social care professional will be responsible for assessing a person's capacity if a decision needs to be made about a move into residential care.

A Court of Protection Deputy or Lasting Power of Attorney may be responsible for assessing capacity for decisions that fall within the scope of their authority.

5.7 Prior considerations when assessing mental capacity

Prior to undertaking an assessment of capacity the assessor must take all practicable steps to support the person to enable them to make the decision.

Following principle 2 of the MCA 2005, *"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."*

Before reaching the conclusion that a person lacks capacity to make a specific decision, it is the responsibility of staff to do everything they can to enable the person to have the best chance of making their own decision. This would involve asking the following questions:

- Does the person, being assessed, have all the relevant information they need to make the decision?
- If they are making a decision that involves choosing between alternatives, do they have information on all the options?
- Would the person have a better understanding if information was explained or presented in another way?
- Are there times of day when the person's understanding is better?
- Are there locations where they may feel more at ease?
- Can the decision be put off until the circumstances are different and the person concerned may be able to make the decision?
- Can anyone else help the person to make choices or express a view? (for example, a family member or carer, an advocate or someone to help with communication) (MCA code of practice:4.36).

If a person can be assisted to make the decision themselves, professionals will not be required to consider further actions under the Mental Capacity Act for that decision.

5.8 The test for Mental Capacity

Anyone assessing someone's capacity to make a decision will need to apply the test as outlined in sections 2 and 3 of the MCA 2005. It can be broken down into three questions:

- Is the person able to make the decision (with support if required)?
- If they are unable, is there an impairment or disturbance in the functioning of their mind or brain?
- Is the person's inability to make the decision because of the impairment or disturbance?

A person is unable to make a decision if they cannot pass the 'Functional Test' as outlined below :-

- **understand information about the decision to be made ('relevant information')** this includes the nature of the decision, the reason why the decision is needed and the likely effects of deciding one way or another, or making no decision at all,)
- **retain that information in their mind (long enough to make the decision)**, a person must be able to hold the information in their mind long enough to use it to make a decision. It does not matter that they could not remember the information prior to the discussion or remember it afterwards, but they do need to be able to keep key pieces of information in their mind at one time, in order to be able to weigh them up
- **use or weigh that information as part of the decision-making process,** in addition to understanding relevant information, people must have the ability to weigh it up and use it to arrive at a decision. Sometimes an impairment or disturbance may cause a person to inevitably arrive at one decision. Although they understand the information, they cannot use it as part of the decision-making process
- **communicate their decision (by any means).** This does not relate to the person's ability to communicate in general, but relates to their ability to communicate what their decision would be if they were allowed to make the decision.

It may be appropriate and necessary for the person assessing capacity to enlist the help of others. For example, a social care practitioner assessing a person's capacity to make decisions about their care needs when being discharged may need to seek an opinion from family and friends, ward staff, or anyone with knowledge of the person. The assessor may also need to ask for an opinion from a practitioner who has specialist training or knowledge about a particular condition or disorder. For example, a Speech & Language Therapist might be able to help if there are communication difficulties; or a clinical psychologist specialising in learning disabilities might be able to offer an opinion about a person's understanding. The final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks

capacity, and not the practitioner who is there to advise.

If the person is unable to do one or more of the above, then they are unable to make the decision, at which point the practitioner must consider the 'diagnostic test' e.g. does the person have an impairment or disturbance in the functioning of the mind or brain. Some examples are:-

- Dementia
- Mental health problems
- Learning disability
- Brain damage
- Concussion
- Delirium
- Intoxication due to drugs or alcohol
- The impact of severe pain
- Emotional distress

For a person to be considered to have an impairment or disturbance of the functioning of the mind or brain, they do not have to have a formally diagnosed condition such as, for example, a mental illness or learning disability. Nor does the impairment or disturbance need to be a permanent condition. Practitioners should avoid doing the diagnostic test before they have completed the functional test, so that they do not make assumptions about a person's capacity based on a diagnosis or condition alone.

If the diagnostic test is met the practitioner, then needs to consider if the reason the person cannot make the decision is due to the impairment or disturbance in the functioning of the mind or brain. Is there a clear link between the functional test and the diagnostic test. This link is known as the 'Causational Nexus'

If a person failed part or all of the functional test and meets the criteria under the diagnostic test and the causational nexus, then they lack mental capacity to make the decision for themselves, and the decision will need to be made on their behalf, in their best interests. If a person is deemed to have capacity to make the decision, then they must be allowed to make the decision for themselves, even if the decision they decide to take appears to others to be unwise.

Capacity assessments are decided on balance of probabilities. In practice, this means deciding whether, on balance, the individual is more likely to have capacity or more likely to lack capacity to make the decision. A Capacity assessment is not some kind of scientific process where capacity is measured; it's a conversation and a value judgement for the person assessing capacity.

All formal mental capacity assessments must be recorded on the Trust Mental Capacity assessment form and must include clear and detailed evidence as to why the assessor has reached their conclusion. (see exemplar in appendix 2)

5.9 Temporary or fluctuating mental capacity

The MCA Code of Practice makes specific reference to people with fluctuating or temporary capacity. The assessor must consider whether the person's lack of capacity is

temporary. This might be due to the effects of drug or alcohol use, or acute illness e.g. a person with a psychotic illness may have delusions that affect their capacity to make decisions at certain times but not at other times; a urinary tract infection can cause a person to temporarily lose capacity to make decisions. What is relevant is the person's ability to make a specific decision at a specific time. In cases of temporary or fluctuating capacity, staff must consider whether it is possible to postpone the specific decision until a later date when a person might have capacity to make it. In an urgent situation, it might not be possible to postpone the decision. Staff must then ensure that they review the person's capacity to make the decision at a suitable future date.

Where a person's capacity to make a decision fluctuates, the assessor can also consider If the person is able to make the decision at a time when they do have mental capacity, so that their wishes can be followed at times when they lack capacity. If the person has capacity more often or not the assessor may take the view that on balance the person does have capacity to make the decision.

5.10 What if the person refuses to be assessed?

There may be circumstances in which a person whose capacity is in doubt, refuses to undergo an assessment of capacity. The code of practice makes it clear that nobody can be forced to undergo an assessment of capacity and if someone refuses to open the door to their home, it cannot be forced.

There are a number of steps that should be considered if a person refuses to engage in the assessment:-

- If applicable, re-allocate to another social care or health professional,
- Consider whether anyone else can facilitate access. This might be a friend neighbour, family member or other professional, who the person engages with,
- Consider whether there is another professional that the person engages with, so they could give an opinion about the person's capacity,
- Consider whether there is an alternative venue. For example, a GP surgery or day centre

If all attempts to engage the person fail, it will be necessary to gather evidence about the person's capacity from:-

- Anything they have written which gives insight into their capacity to make the specific decision,
- Any witness who can give information about the person's capacity to make the decision in question. This could be from family, friends, neighbours, carers or other practitioners.

If it has not proved possible to engage with the person, the assessor can make an assessment of capacity based on this evidence.

5.11 Mental capacity and consent to treatment

A person cannot give consent to any form of treatment or intervention, unless they have the mental capacity to do so. Just because a person is compliant and not resistive to treatment does not mean that they have the mental capacity to consent. If there is any doubt about their mental capacity to consent then an assessment must be undertaken**.** This also applies to a person's ability to consent to hospital admission. A patient who cannot consent to being in hospital is likely to be deprived of their liberty and therefore requires a legal framework either under the Mental Health Act (MHA) 1983 or under Deprivation of Liberty Safeguards (DoLS), they cannot be admitted on an informal basis.

5.12 Best Interest decision making

When it is established that an individual lacks capacity to make a particular decision, section 4 of the MCA 2005, requires 'best interests' as the criterion for any action taken or decision made on that person's behalf. It should not be the personal views of the decision maker. Instead, it considers both the balanced approach of the pros and cons of the options available for the person and decides what course of action is, on balance, the best course of action for them.

Before making a best interest decision the person who is going to make the decision needs to be identified.

The person who decides what is in a person's best interests is referred to in the MCA 2005 as the 'decision-maker'. The decision maker is the person who is proposing to take action in relation to the decision.

Under the MCA, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions in relation to certain things:-

- For most routine decisions, this may be the person caring for, or supporting the person on a day to day basis
- For medical interventions, it is likely to be the Doctor or whoever is responsible for carrying out the particular treatment or procedure
- For social services care plans, the best interest's decision maker may be the relevant social care practitioner
- An attorney under a Lasting Power of attorney (LPA) or a court appointed deputy will be decision maker within the scope of their authority (an LPA may be for health and welfare decisions, or it may be for property and finance decisions. The decision making scope of a court appointed deputy will be outlined in a court order from the Court of Protection (CoP))

Where the decision maker appears to be an attorney under a relevant LPA the practitioner involved in the case should check the status of the LPA by contacting the Office of the Public Guardian (OPG) to request they check the register. The OPG can also check details of any court appointed deputies who will also be on their register.

There is no definition of 'best interests' in the MCA. Instead, s.4 of the MCA sets out a 'checklist' of factors that the decision maker must apply when determining what is in a person's best interests (See Appendix 7) The Best Interests Checklist). Staff must follow this checklist when making a best interests decision:-

- Encourage Participation - Make every effort to permit and encourage the person to participate in the decision to be made.
- Identify all relevant circumstances - Identify all the relevant issues and circumstances relating to the decision in question.
- Find out the person's wishes, feelings, beliefs and values, past and present.
- Avoid discrimination - the decision must not be made merely on the basis of the person's age or appearance, race, religion, sexuality or sex. Show equal consideration and non-discrimination.
- Assess whether the person might regain capacity and if so, whether the decision can be delayed.
- If the decision concerns life-sustaining treatment, staff must not be motivated in any way by a desire to bring about the person's death.
- Consult others: including family, carers, advocates, attorneys, deputies, other practitioners, and anyone named by the person themselves.
- Avoid restricting the person's rights - the decision maker must assess whether there is a less restrictive option,
- Take all of this information into account when deciding on the best interest decision

Having considered all of the above the decision maker should then consider all of the available options and complete a balance sheet exercise where they should consider the pros and cons of each option, this will help them to identify the option that best meets the person's needs and is as lest restrictive as possible.

The decision maker if they are employed by the Trust must complete the Trust's formal best interest form and save it on the person's case notes. (see exemplar in appendix 4) All of the above discussions and consultations should be outlined on the form, along with the balance sheet exercise and the final decision that is made. If the decision maker is an attorney or deputy, the practitioner most involved with the person must assist the decision maker in the best interest process and record it on the Trust best interest form.

5.13 What if there is a disagreement about best interests?

In the first instance, if there is a disagreement amongst interested parties such as family members, practitioners and the person themselves, the decision maker should convene a best interest meeting. The purpose of the best interest meeting is to allow everyone to

express their views and hear the views of others. However the final decision about what will happen remains with the decision maker.

If following the best interest meeting there are still strong objections to the decision that has been made the lead practitioner should contact the Trust legal department and discuss with them the possibility of referring the matter to the Court of Protection (CoP) for them to rule on the matter (see Trust policy on managing MCA disputes MCA: Dispute Process for Mental Capacity and Best Interest Decisions Policy CLP143 (Trustwide) - Interact)

5.14 Advance decision and advance statements

An adult aged 18 or above can make an advanced decision to refuse a specific treatment, provided at the time they make that decision they have the mental capacity to do so. An advanced decision does not have to be in writing unless the treatment it relates to is life sustaining treatment for example Cardio Pulmonary Resuscitation (CPR) For life sustaining treatments an advanced decision must be in writing, signed and must be witnessed by someone else.

When making an advanced decision the person must be clear what treatment they wish to decline and must be clear that it is their decision and that they are not being forced to make it. For life sustaining treatment they must be clear that they understand that not having the treatment may result in their death.

If an advanced decision has been properly made, it is legally binding, and practitioners must respect the wishes of the person even if they subsequently lose mental capacity to make the decisions about treatment for themselves. The only instance where an advance decision can be overridden is in relation to treatment for a psychiatric disorder when the person has been detained in hospital under a section of the Mental Health Act 1983 (MHA)

A person may also make an advance statement of wishes, in which they outline what the would like to happen if they should lose capacity to make decisions for themselves at some point in the future. These advance statements are not legally binding, but should always be taken into consideration when making a best interest decision on behalf of a person who lacks capacity to make a certain decision. Wherever possible the wishes of a person should be followed, unless to do so would cause them significant harm.

For further information regarding advance care planning see the attached Trust guidelines: Advance Care Planning Guideline CLG170 (Trustwide) - Interact

5.15 Lasting Power of Attorney

Anyone aged 18 or above can make plans for the future, by creating a Lasting Power of Attorney (LPA). The purpose of a Lasting Power of Attorney is to enable a person with mental capacity to delegate decision making powers to someone of their choosing, who can then make decisions on their behalf should they lose mental capacity in the future.

There are two types of LPA:-

- Health and Welfare (relates to decisions that may need to be made about a person's

health and care, such as medical treatment, social care and accommodation)

- Property and Finance (relates to decisions about how a person's property such as their home and possessions are managed and how their money is managed and spent on their behalf.

For a Health and Welfare LPA to become active the person who made it has to have lost the mental capacity to make certain health and welfare related decisions.

For a property and Finance LPA to become active the person who made it can ask their designated attorney or attorneys to help them with their finances even if they still have mental capacity to make decisions for themselves, this is so that a person who is physically unable to get out to a bank etc can ask their attorney to do it on their behalf.

At any time a person who still has mental capacity can revoke any LPA they have made in the past, however if they have lost mental capacity to do so they cannot revoke the LPA

An LPA is a legally binding written document, which can be created on the relevant forms either through the help of a solicitor or by the person themselves by downloading the relevant forms from the Office of The Public Guardian. LPA forms need to be signed for by the person themselves and they need to be witnessed and signed by the witness. There is also a requirement the someone other than a witness or proposed attorney confirm that the person making the LPA has mental capacity to do so and is not being coerced into making the LPA. Anyone named as being an attorney must consent to taking on that role

Once the paperwork has been completed it needs to be sent to The Office of The Public Guardian (OPG) who will check the forms have been completed properly and will then place them on the register. If the LPA has not been registered with the OPG then it is not valid.

When choosing who will be the attorneys in and LPA the person can choose more than one person to act on their behalf. Where there is more than one attorney named they can specify how those attorneys act in the following ways:-

- Jointly – this means that if there is more than one attorney they have to make any decisions together, they cannot make a decision on their own without the agreement of the other attorney or attorneys.

- Jointly and severally – This means that one attorney can act alone to make a decision, if the other attorneys are not available to make a decisions.

The OPG will hold details of how the attorneys are authorised to act on the documents they hold on the register.

When a practitioner is advised by someone that they are an attorney under and LPA for a person who has lost mental capacity to make certain decisions, it is important that the practitioner confirms that this individual has the legal powers that they claim to have. The best way to do this is to request the OPG check the register and confirm if an LPA exists, what it is for and who is named as being the attorney.

The role of the attorney under an LPA is to make decisions on behalf of the person who made the LPA in their best interests. Attorneys under an LPA are legally obliged to follow the Best Interest Checklist as outlined in section 4 of the MCA 2005. If there are concerns that an attorney is not acting in the best interests of the person, the OPG should be advised of these concerns. The OPG will then undertake an investigation and if the concerns are confirmed they may apply to the CoP to request that the LPA is either suspended or revoked.

Where there is more than one attorney under and LPA and they are the decision makers, there may be occasions where there is a disagreement between the attorneys, if this is the case they should be invited to attend a best interest meeting and supported to resolve any disagreements. If this fails then the CoP may need to be approached to resolve the matter.

5.16 Court appointed deputies

Where a person has lost mental capacity to make certain decisions, but there is no LPA in place there may be a need to approach the CoP as them to appoint a Deputy, to make significant decisions on behalf of the person. This is often the case in relation to property and finance, were significant financial decisions such as the sale of property or the management of savings is required. Anyone over the age of 18 can apply to be a court appointed deputy, and often family members will apply to the CoP to become deputies. Where there are no family members available and a deputy is require organisations such as the local authority may make an application for deputyship. When the CoP makes a deputyship order it will specify what types of decision the deputy can make and will also specify a time period for the deputyship to be in place.

As with LPAs Deputyship orders are registered with the OPG and can be checked for their validity in the same way as an LPA. Deputies have the same legal responsibilities to make decisions that are in the person's best interests in the same way that an attorney under an obliged to act. The OPG can investigate a deputy if it is felt they are not acting in a person's best interests and as with LPAs the CoP can revoke a deputyship order.

5.17 Independent Mental Capacity Advocates

As part of the best interest process, it is important that the person the decision is being made for has access to someone who can advocate on their behalf. In many cases this will be a family member or close friend, however in some cases there is no one who can advocate for the person. In these cases where the decision being made is a significant one, practitioners must request that an Independent Mental Capacity Advocate (IMCA) is appointed by the commissioned advocacy service. In the case of Gloucestershire this is POhWER.

Any IMCA that has been appointed to support a person who lacks mental Capacity to make certain decisions must be included in any best interest decision making process and should be invited to any best interest meetings.

The role of the IMCA is to advocate on behalf of the person who lacks mental capacity. They will put forward the views and wishes of the person. However, they are not the

decision maker.

6 DEPRIVATION OF LIBERTY

6.1 What is a deprivation of liberty?

In March of 2014 the UK Supreme Court ruled in the case of *P v Cheshire West and Chester Council & Anor [2014] UKSC 19.* As part of this ruling they clarified what constitutes a deprivation of liberty, by outlining what is known as the 'Acid Test'. The Acid test states that a deprivation of liberty is occurring if the person lacks mental capacity to consent to care and treatment arrangements and is:-

- Not free to leave (meaning they are not free to go and live in another place)
- Are under continuous supervision
- Are under continuous control

The Court also clarified that for a deprivation of liberty to be occurring it does not matter if the person in question is objecting to their confinement or not. Even if they are compliant with the care arrangements, they are still deprived of their liberty.

In addition to the above a deprivation of liberty will be occurring if the Acid Test is met and the care and treatment arrangements are 'Imputable to the State' This means that a state body, such as an NHS trust or local authority, is involved in providing/responsible for the care and treatment the person is receiving.

Continuous supervision could include the following:-

- Having staff present within the place the person lives 24 hours a day.
- Having electronic monitoring, such as video cameras or door sensors.
- Escorting a person when they go out of the building.
- Monitoring how long a person is away from the building if they go out alone and taking steps to return them if they do not come back when expected.
- Undertaking regular daily checks on a person or having them under continuous observation.

This is not an exhaustive list.

Continuous control could include the following:-

- Providing personal care including continence care
- Deciding what clothes a person should wear
- Completing medical observations such as: temperature, blood pressure and Sats
- Deciding what food and drink a person eats and when they eat and drink
- Deciding when they get up
- Completing assessments
- Monitoring urine output
- Deciding who visits them and when
- Deciding when they can go out a who with

- Deciding what areas within the building thy can have access to
- Holding and managing their money
- Using restraint, both physical and chemical

This is not an exhaustive list.

If a person is found to be subject to health and care arrangements that amount to a deprivation of liberty these arrangements must be authorised through a legal process, which must also provide the person with access to appeal the against the deprivation of liberty that is occurring. Failure to legally authorise a deprivation of liberty will put the organisation responsible for that person's care in breach of The Human rights Act 1998 and article 5 of the European Convention on Human Rights (ECHR).

6.2 Deprivation of Liberty Safeguards

For people who are deprived of their liberty in hospital inpatient settings, residential and nursing homes, The Deprivation of Liberty Safeguards (DoLS) were created as an amendment to the MCA 2005 in 2007 following a ruling by the European Court of Human Rights (ECtHR) in the case of HL v UK 45508/99 [2004] ECtHR 471 often referred to as the "Bournewood" case.

Where a person is residing in hospital or registered care home and they are deprived of their liberty, then the organisation that manages the place the person is in, is known as the Managing Authority. The case of GHC hospital inpatient settings the Trust is the managing authority.

The Managing Authority has a legal responsibility to put in place a 7 day Urgent DoLS authorisation, where it identifies that they are providing care to a person who lacks capacity to consent to residing in that place for care and treatment and the care and treatment amounts to a deprivation of liberty.

At the same time that the Managing Authority puts in place a 7 day Urgent authorisation they must also make a referral to the local authority DoLS team requesting that they assess the person with a view to them being placed on a Standard DoLS authorisation which can last for up to 12 months. A doctor and a best interest assessor will then be commissioned by the local authority DoLS team to undertake a full DoLS assessment of the person to establish if the current health and care arrangements and the placement are in the person's best interests. If it is decided that the arrangements are appropriate then the local authority will authorise the deprivation of liberty for a set period of time of up to 12 months. (see appendix DoLS flow Chart) At the end of the period of the Standard Authorisation the Managing Authority must request a further Standard Authorisation form the local authority if the criteria for a DoLS is still met.

As part of the authorisation the local authority will also identify someone to act as the Relevant Person's Representative (RPR) who is responsible for providing support to the person who is subject to the DoLS and where appropriate take steps to refer the person to the CoP for appeal, if they feel the person is objecting to the deprivation of liberty. The RPR may be a family member or close friend of the person, or in the absence of these

may be a paid RPR who would be provided by our local commissioned advocacy service POhWER

Where an RPR is in place the Managing Authority, must allow them access to the person and their notes and records on request.

When someone is placed on either an Urgent or Standard Authorisation it is the responsibility of the Managing Authority to inform the person of their legal rights in relation to the authorisation, both verbally and in writing. The person must be given a copy of of the DoLS rights leaflet that is relevant to the type of DoLS they are under (see Appendix and for copies of the Trust DoLS rights leaflets) The DoLS rights should be provided to the person every couple of weeks, to allow them every opportunity to be able to understand them

A DoLS authorisation is only valid in relation to the place specified when the DoLS is authorised and cannot be used if they move to another setting. If the person moves a new DoLS authorisation needs to be considered if appropriate.

Where an inpatient setting in the Trust has placed someone on a 7day Urgent authorisation and they are awaiting the Local Authority to complete a standard authorisation assessment, they must keep in contact with the local authority DoLS team to ask them for an update on when the person will be assessed. Where an inpatient is under either and Urgent or standard authorisation and their circumstances or presentation changes, the inpatient setting must advise the DoLS team of any changes. Any DoLS in place will end if a patient is discharged, transferred to another hospital or passes away.

Where someone is an inpatient who is detained under a section of the Mental Health Act (MHA) 1983 and who meets the criteria for a deprivation of liberty, they will not be eligible for a DoLS authorisation as their deprivation of liberty is already authorised by the MHA, which also provides them with access to an appeal against their detention. A person who is subject to a Community Treatment Order (CTO) or a Guardianship Order (GO) under the MHA 1983 can also be subject to a DoLS authorisation if they meet the above criteria and the requirement of the DoLS do not conflict with the requirements of the CTO or GO.

6.3 Court of Protection Deprivation of Liberty Orders

Someone living in a community setting, such as a family home, supported living or an adult placement may also meet the criteria for being deprived of their liberty, however a deprivation of liberty in a community setting cannot be authorised through the DoLS process. Therefore in order to authorise a deprivation of liberty an application needs to be made to the Court of Protection (CoP), so that if they agree the deprivation is appropriate then they can make a Deprivation of Liberty Order (CoPDoLO)

When it is identified that a deprivation of liberty is taking place in the community, and an application to the CoP is required, it is necessary for it to be established which organisation is responsible for the care arrangements which are in place as it is that organisation who will be responsible for making the application. Where care arrangements are being funded mostly by the local authority or another organisation such as the ICB, it will not be the responsibility of GHC to make the application to the CoP, however if staff within the Trust

have identified that an application to the CoP is required then they should take steps to advise the organisation that they believe is responsible, that a deprivation of liberty is occurring and that a referral to the CoP is required.

In a very small number of cases where GHC are the only agency involved in providing healthcare and support to someone who is deprived of their liberty in the community, it is the Trust who will need to make the application to the CoP. In these cases practitioners should discuss the case with their line manager, who should then seek advice from the Trust Legal services about what the next step in the process is.

Prior to any application being made to the CoP the practitioner responsible for the case must ensure that robust mental capacity assessment and best interest processes are in place for any aspects of care that the person is unable to consent to. There will also need to be a clear and robust care plan in place. These documents will need to be sent to the CoP as part of the court process.

6.4 MCA 2005 and deprivation of liberty for 16 and 17 year olds

The MCA 2005 applies to anyone aged 16 and above, however there are certain aspects of the MCA 2005 that do not apply to people aged 16 and 17. The details are as follows:-

- A 16 or 17 year old with mental capacity can consent to or decline treatment, but cannot refuse treatment if that treatment is required to prevent long term harm or death.

- A 16 or 17 year old cannot make an advanced decision to refuse treatment.

- A 16 or 17 year old cannot make a Lasting Power of Attorney or be an attorney or deputy for someone else.

- A 16 or 17 year old cannot have a deprivation of liberty authorised through the DoLS process even where they are residing in hospital or a registered care home setting.

As stated above where a 16 or 17 year old is deprived of their liberty the DoLS process cannot be used, in addition to this case law has established that a parent with parental control cannot authorise a deprivation of liberty for a child aged 16 or 17. In these circumstances the matter needs to be referred to the Court of Protection for an authorisation as outlined in the section above. For further information please see the following guidance: Decision Making in Children's Services Clinical Guideline (CLG171) - Interact

6.5 Advice and support

The Trust currently has a full time MCA Lead post as a job share. The MCA leads can provide advice and support to Trust staff in relation to the MCA 2005 and deprivation of liberty issues. Each week the leads put aside half a day for an MCA drop in session that staff members can access. To access these sessions staff can contact the MCA leads by email, they will then be sent and MS teams link inviting them to attend the next available

drop in session.

In addition to the MCA leads, a number of teams throughout the Trust have a team member who is designated as their MCA Champion. The MCA Champions have access to monthly champions meetings and a range of resources that are shared at these meetings. The champions role within their teams is to help support colleagues within their teams in relation to any issues they have regarding the MCA or deprivation of liberty. Anyone wishing to become a champion can do so through contacting the MCA leads by email.

PART 3 – Explanatory information

This part should include explanatory information to support the requirements set out in Part 2. It should include the following sections.

7. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Only include requirements and methods that are currently monitored to the frequency shown – evidence of these can be requested by external regulators.

Please see this guide for further advice on how to complete this section – the guide also shows examples: Process for Monitoring Compliance Completion & Examples

Monitoring Requirements and Methodology	Frequency	Further Actions
Audits in relation to the following aspects of the MCA are undertaken and action plans created as a result of these audits:- Community Hospital mental capacity compliance audit MCA assessment and best interest form trust wide audit Berkeley House MCA compliance audit	 Annually Annually Annually	Following each audit smart action plans are created and put in place to improve compliance going forwards
In addition to the above audits the MCA leads complete case reviews for cases on one ward a month within community hospitals.	Monthly	Following each monthly case audit feedback is shared with the ward managers and senior

		managers
All clinical managers are being trained to undertake dip audits of MCA assessments and best interest forms and will commence these audits going forwards	Monthly	Managers will feedback their findings in team meetings and through 1 to 1 supervision sessions.

8. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

8.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

9. TRAINING .

9.1 All Trust staff have to complete mandatory level 1 MCA e-learning on care to learn, this is a one off requirement.

For all band 6 and 7 clinical staff the level 2 MCA web based learning is essential to role and must be completed every 3 years. Staff can book onto this training through Care to Learn. Other band of staff can also access the level 2 training if they wish.

Training is also available for staff to access in relation to The MCA and decision making for children. This is web based training and can be booked through Care to Learn.

MCA leads can also be contacted by clinical team mangers to request bespoke face to face MCA training for their teams.

Please contact Learning and Development or Practice Education for guidance. Competency templates are available on request.

10. REFERENCES

P v Cheshire West and Chester Council & Anor [2014] UKSC 19. P (by his litigation friend the Official Solicitor) (FC) (Appellant) v Cheshire West and Chester Council and another (Respondents) - UK Supreme Court

HL v UK 45508/99 [2004] ECtHR 471 003-1154118-1197068.pdf

Mental Capacity Act 2005 Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice Mental-capacity-act-code-of-practice.pdf

Deprivation of Liberty Safeguards Code of Practice 12369 Mental Capacity 18th.indd

Mental Health Act 1983 and 2007 Mental Health Act 1983 Mental Health Act 2007

Human Rights Act 1998 Human Rights Act 1998

European Convention on Human Rights European Convention on Human Rights

Where the document refers to other documents or is based on other documents or where another document explains matters in greater detail, the titles should be listed here. All policy documents must cite references in full, using Arial font size 12 in italics. Where they are accessible online, the address should be given (so long as they are not subject to frequent change)

11. ASSOCIATED DOCUMENTS

Decision Making in Children's Services Clinical Guideline (CLG171) - Interact

Advance Care Planning Guideline CLG170 (Trustwide) - Interact

MCA: Dispute Process for Mental Capacity and Best Interest Decisions Policy CLP143 (Trustwide) - Interact

Consent to Examination or Treatment Policy (CLP213) Trustwide - Interact

Non-Compliance with Treatment Regimes Policy (CLP216) Trustwide - Interact

Advocacy Guideline (CLG150) Trustwide - Interact

APPENDICES

Appendices should be on separate pages for each appendix at the end of the policy or if preferred these can be sent as separate documents to the policy and will be linked into the contents by the administrator.

Include as an appendix other documents which are an essential element of the current document, such as a ***document template****. Wherever possible, include a* ***flowchart*** *to illustrate any process required by the policy.*

Action Cards (if required) normally sit before the Introduction section in part 2 above – a policy template with action card template inserted is available on request from: clinical.policies@ghc.nhs.uk

Appendix 1: Mental Capacity Assessment (MCA) Form - Interact

Appendix 2: Best Interest Form - Interact

Appendix 3: Mental Capacity Assessment (MCA) Exemplars - Interact

Appendix 4: Best Interests Form Exemplars - Interact

Appendix 5: MCA Assessment Flowchart - Interact

Appendix 6: Best Interests Decision Flowchart - Interact

Appendix 7: Best Interest Checklist - Section 4 Mental Capacity Act 2005 - Interact

Appendix 8: 
Deprivation of Liberty Safeguards flc