NHS
Kernow
Clinical Commissioning Group

Mental capacity act and deprivation of liberty safeguards policy

Date approved: 31 May 2022

Document control sheet

Title of document: Mental capacity act and deprivation of liberty safeguards policy
Originating directorate: Nursing and quality
Originating team: Mental capacity act and deprivation of liberty safeguards (DoLS)
Document type: Policy
Subject category: Nursing and quality
Author(s) name: Rebecca Evans, MCA and DoLS Lead Nurse
Date ratified: 31 May 2022
Ratified by: Quality committee
Review frequency: 3 years (standard, unless otherwise indicated)
To be reviewed by date: 31 May 2025
Target audience: All staff
Can this policy be released under FOI? Yes
Give reasons for exemption if no: N/A

Version control

Version number	Revision date	Revision by	Nature of revisions
V1.0	26 March 2022	MCA and DOLS lead Nurse	Details of revisions
V2.1	08 April 2022	MCA and DOLS lead nurse	Amended after comments from CHC team about their roles
V2.2	14 April 2022	Head of nursing	Accessibility and terminology
V2.3	25 May 2022	Head of nursing	Minor amendments and completion of impact assessment
V3	31 May 2022	Quality committee	Ratification by the Quality committee
V3	June 2022	Governance team	Further accessibility and governance checks

Contents

1. Introduction

This policy describes the way in which NHS Kernow as the clinical commissioning group 'the CCG' for Cornwall and the Isles of Scilly will implement its duties and responsibilities in relation to safeguarding children and includes the CCGs expectations for services from which we commission care.

Please note, during the transition process to the establishment of the Cornwall and Isles of Scilly Integrated Care Board (ICB), this policy will remain relevant and used by NHS Kernow both prior and post transfer to the ICB.

The Mental Capacity Act (MCA) 2015 consolidates human rights law for people who may lack the capacity to make their own decisions. It promotes the empowerment of individuals and the protection of their rights. The act applies to anyone aged over 16 years or over in England and Wales and is relevant for both care and treatment decisions.

This policy should be read in conjunction with:

- MCA code of practice
- MCA easy read guide
- Deprivation of Liberty Safeguards (DoLS) resources

The act is built on 5 statutory principles that guide and inform decision-making in respect of the estimated 2 million people who may lack capacity for decision making in some aspects of their life including their health care. (Social Care Institute for Excellence 2015)

The MCA 2005 key principles:

1. A presumption of capacity: every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. Support individuals to make their own decisions: people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. Right to make an unwise decision: people have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.
4. Best interest: anything done for or on behalf of people without capacity must be in their best interests.
5. Least restrictive option: anything done for or on behalf of people without capacity should be the least restrictive.

The MCA is the essential and required framework for both health and social care commissioners and practitioners, particularly when working with people who may be unable to, permanently or temporarily, take some or all decisions about their care and treatment.

Through a good understanding of the act, providers and commissioners can ensure that appropriate assessments of capacity are carried out and that decisions made on behalf of incapacitated people are in their best interests.

The act is part of a framework within which healthcare providers should be working to ensure they respect patients' dignity and human rights. This framework includes:

- Human Rights Act 1998
- MCA 2005 including the Mental Capacity Amendment Act 2019
- Disability Discrimination Acts 1995 and 2005
- Equality Act 2010

The MCA is rights legislation. It protects the rights of all persons to take as many decisions about themselves for as long as possible. It places on staff a duty to help persons make decisions for themselves. If they cannot, it sets out a clear and robust process for determining whether patients have capacity and if they do not, how decisions should be made on their behalf.

The act lays down the firm principle that because a person cannot make a particular decision it does not automatically follow, they cannot make the next one required of them; therefore, the person's capacity is decision specific.

What is capacity

NHS England describes capacity:

"Capacity means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that time."

Someone with such an impairment is thought to be unable to make a decision if they cannot:

- understand information about the decision
- remember that information
- use that information to make a decision
- communicate their decision by talking, using sign language or any other means

This is set out in the Mental Capacity Act 2005 and the MCA code of practice.

2. Purpose

To outline the responsibilities of NHS Kernow in applying the MCA code of practice, with regard to ensuring that as commissioners of services these responsibilities are also adopted by those that we commission services from.

NHS Kernow, as the clinical commissioning group ('the CCG') for Cornwall and the Isles of Scilly has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare and rights of vulnerable adults and young people, including for the purposes of the MCA, those people who are over the age of 16, and receive care, treatment and/or services funded by NHS Kernow by ensuring that:

- the services commissioned by NHS Kernow provide safe, effective and high-quality care for vulnerable children and adults, including adults who lack capacity
- the care commissioned by NHS Kernow is compliant with the MCA 2005 and that providers fulfil their statutory responsibilities to people who access services
- that all staff employed by NHS Kernow are aware of and fulfil their responsibilities under the MCA, and that their staff operate at all times in accordance with the statutory framework and the code of practice
- that all staff employed by NHS Kernow are aware of and fulfil their responsibilities under the deprivation of liberty safeguards and that their staff operate at all times in accordance with the statutory framework and the code of practice
- that NHS Kernow undertake yearly safeguarding adults and children's mandatory e-learning training which incorporates MCA training

3. Clinical commissioning groups

NHS Kernow will need assurance that the Act is embedded in the work of commissioned organisations with their patients and will want to ensure that:

- as an organisation it fulfils all its duties relating to the act
- the MCA is embedded in all elements of the commissioning cycle
- its staff understand the importance of compliance with the MCA and ensuring that staff are aware, as appropriate for their role
- assessing compliance and what needs to be done to achieve this is a key part of tendering and contract award
- ongoing compliance is monitored in detail through performance review and quality monitoring processes

What the Mental Capacity Act 2005 is important to CCGs?

CCGs need to ensure that the services they are commissioning on behalf of local populations are being delivered in a way that both respects and applies the rights of individual persons and, in particular, those that are vulnerable and may not be able to take decisions on their own behalf.

In certain circumstances, failure to provide care within the framework set down by the act could be deemed to be unlawful. This could arise from noncompliance by CCG staff who have direct contact with patients and also by noncompliance when making commissioning decisions about individual packages of care.

As part of their authorisation process, CCGs are requested to have a lead for the MCA 2005, supported by training and policies. CCGs may need to demonstrate how they have discharged this duty.

As a commissioner we are seeking evidence of an embedded cultural shift within organisations. Clinical engagement should be rights based. Decisions should be made on the basis that persons have a right to make their own decisions and this should only be removed as the exception and only on clear evidence that the assumption of capacity be put aside and in accordance with the framework set down in the act.

4. Responsibilities

Accountable officer

The accountable officer is accountable for:

- ensuring that the CCG fulfils its MCA and deprivation of liberty duties effectively
- ensuring that MCA and deprivation of liberty quality assurance processes are in place through contractual arrangements with all provider organisation
- providing strategic leadership that promotes a culture of supporting good practice about MCA and deprivation of liberty within the CCG
- providing strategic leadership that promotes collaborative working with other agencies
- ensuring that the health contribution to MCA and deprivation of liberty is discharged effectively across the local health economy through the CCG's commissioning arrangements

Chief nursing officer

The chief nursing officer is accountable to and reports to the accountable officer.

The chief nursing officer acts as the executive lead for MCA and deprivation of liberty, providing professional advice to the CCG's governing body and the quality committee including all related statutory and commissioning issues; supported by the deputy director of nursing, head of nursing and the MCA lead.

The chief nursing officer also ensures that the policy is delivered effectively as part of place-based care, providing the strategic leadership to enable the CCG to fulfil its duties to cooperate and provide assurance to external bodies.

Deputy director of nursing

The deputy director of nursing is accountable and reports to the chief nursing officer and deputises for them. They support the chief nursing officer, providing NHS Kernow with the capacity to meet all the statutory duties in relation to the MCA. It also ensures that the accountable officer, directors, and governing body can access professional advice in relation to the MCA when required.

The deputy director of nursing is responsible for managing the process of implementation and evaluation of this policy, as well as preparing submissions on a regular basis to the quality committee.

Head of nursing

The head of nursing reports to the deputy director of nursing and is accountable to the chief nursing officer.

They are responsible for the development and oversight of programmes of work to embed and implement the MCA.

The head of nursing applies an approach of continuous improvement in order that local, regional, and national requirements are met.

MCA lead

The MCA lead reports to the head of nursing and is accountable to the chief nursing officer.

The MCA lead has a strategic professional lead role as a subject matter expert in their relevant fields of MCA and DoLS and is responsible for the implementation of the MCA work plan.

The MCA lead also oversees the work of NHS Kernow's MCA team for those people that receive funding from NHS Kernow, are deprived of their liberty and the deprivation of liberty needs to be authorised by the court of protection. The MCA lead takes responsibility, in conjunction with the head of continuing healthcare (CHC) for the implementation of the liberty protection safeguards as set out in this framework.

Designated, named, and lead safeguarding professionals

The designated, named and lead safeguarding professionals have a strategic professional lead role as subject matter experts in their relevant fields of safeguarding. They work across every aspect of health service contribution to safeguarding within all provider organisations commissioned by the CCG and across the health community and wider partners.

As clinical experts, the safeguarding professionals are responsible for enabling the implementation of the activities in this policy and ensuring that objectives are aligned with the objectives of local safeguarding boards and partnerships.

Head of continuing healthcare adults

This role is designed to implement and monitor the continuing healthcare (CHC) work programme. Part of the role is to ensure that an effective response is provided by the CHC team when a person funded by CHC is believed to lack capacity and provide assurance to the CCG about its response in accordance with this policy. They are responsible for ensuring the CCG is compliant with the requirements of the Mental Capacity Act 2005 for people who are CHC funded. The head of CHC will take responsibility, in conjunction with the MCA lead for the implementation for the liberty protection safeguards.

Head of continuing healthcare children

This role is designed to manage the programme of work relating to children who have complex needs and are in receipt of funding from NHS Kernow. For those young people who are 16 and over, to ensure compliance with the MCA 2005.

CHC nurse assessors and coordinators

Expectation of the coordinators who are assessing a person for CHC eligibility:

- be able to apply the MCA in accordance with their day-to-day work and evidence this in records
- recognise a deprivation of liberty
- check a DoLS authorisation is in place
- recognise a situation which may need escalation to the Court of Protection and to refer to the MCA lead

Mental health commissioning team

To ensure that the MCA's principles are considered in all commissioned care.

All staff

To have an awareness of the MCA and how to contact the MCA team with any queries.

5. MCA training and supervision

NHS Kernow will set out how all staff receive the correct training for MCA in a CCG safeguarding training strategy.

The training is required to promote the best practice by staff regarding the principles of the MCA.

Supervision can be provided by the MCA team in relation to the person's experience of implementing the act, this can be accessed by contacting the MCA lead.

6. Co-commissioning arrangements

Under the delegation arrangements, the CCG are responsible for ensuring that GP services commissioned have effective MCA arrangements in place. The overall effectiveness of the CCG in discharging its duties will be monitored as part of the CCG assurance process.

7. Deprivation of liberty safeguards

The deprivation of liberty safeguards (DoLS) within the MCA provides a legal protective framework for those vulnerable or at risk people who are deprived of their liberty and not detained under the Mental Health Act 2005 or any other legal process.

Article 5 of the European Convention on Human Rights states: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save... in accordance with a procedure prescribed in law."

The safeguards apply to people 18 years old and above; in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. Local authorities currently have the responsibilities and powers to authorise the deprivation of liberty for people who are in hospitals and care homes. In the event of it being necessary to deprive a person of their liberty the safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed.

People can be deprived of their liberty in settings other than hospitals and care homes such as supported living, but in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations in such circumstances should be made to the court.

The MCA gives certain responsibilities to staff caring for vulnerable people who lack the capacity to consent to their care and treatment to use restriction and restraint where it is in the best interests of the person and is necessary to prevent harm. If, however, that restriction and restraint move towards depriving that person of their liberty, it could be unlawful unless authorised by the relevant local authority following an assessment process determined in law.

Acid test

The UK Supreme Court made a ruling on the test for whether a deprivation of liberty is occurring. This only applies to people who do not have capacity to consent to their own care and treatment:

1. Is the person subject to continuous supervision and control?
2. Is the person not free to leave?

If the answer is yes to both questions, then it is almost certain that a deprivation of liberty is occurring, but every person must be considered individually.

Deprivation of liberty in domestic settings

The Supreme Court held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements, it must be authorised by the Court of Protection.

If the person is fully NHS funded by the CCG, then an application to the Court of Protection should be made by the CCG. If the person is joint funded, then a discussion with the other responsible commissioner will be necessary to decide whether a joint application will be made or whether one party will be the lead respondent in the application to the court. Please see The Court of Protection

8. Liberty protection safeguards

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the DoLS system. The liberty protection safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The liberty protection safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

There is presently no definitive date for the implementation of the liberty protection safeguards.

9. The Court of Protection

This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The court makes decisions and can appoint deputies to make decisions in the best interests of those who lack capacity to do so.

The act provides for a new Court of Protection to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The court also has the power to make declarations about whether someone has the capacity to make a particular decision. The court has the

same powers, rights, privileges, and authority in relation to mental capacity matters as the High Court. It is a superior court of record and can set precedents (set examples to follow in future cases).

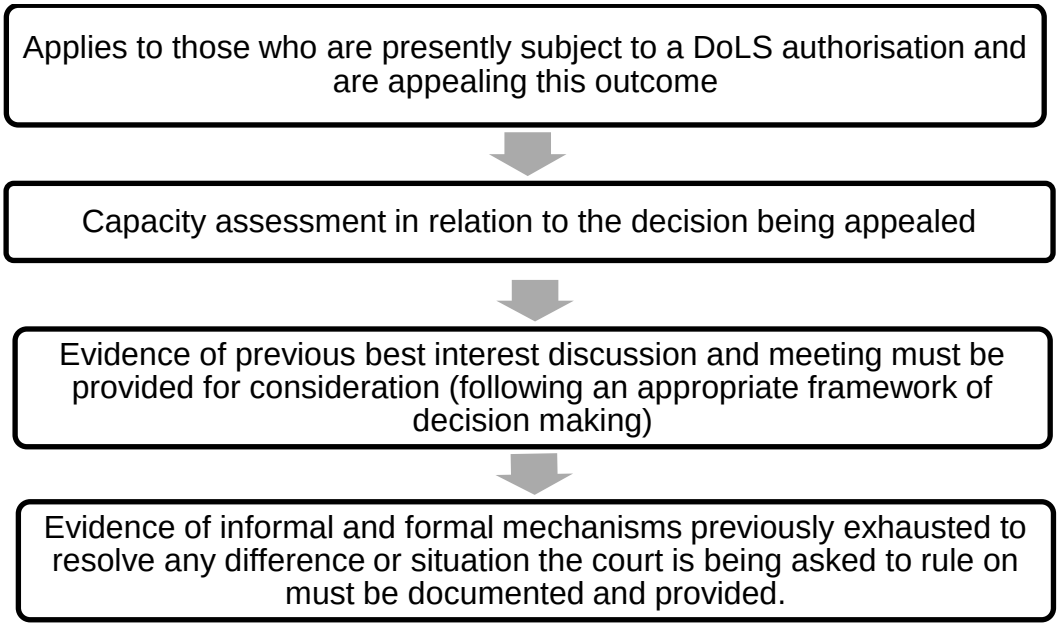
The Court of Protection has the powers to:

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

Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian. Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are also available from the Office of the Public Guardian.

NHS Kernow must be assured that all informal and formal internal mechanisms have been exhausted before making any application to the Court of Protection. However, where an application is required, this must not be delayed.

Process for consideration when use of the Court of Protection is required

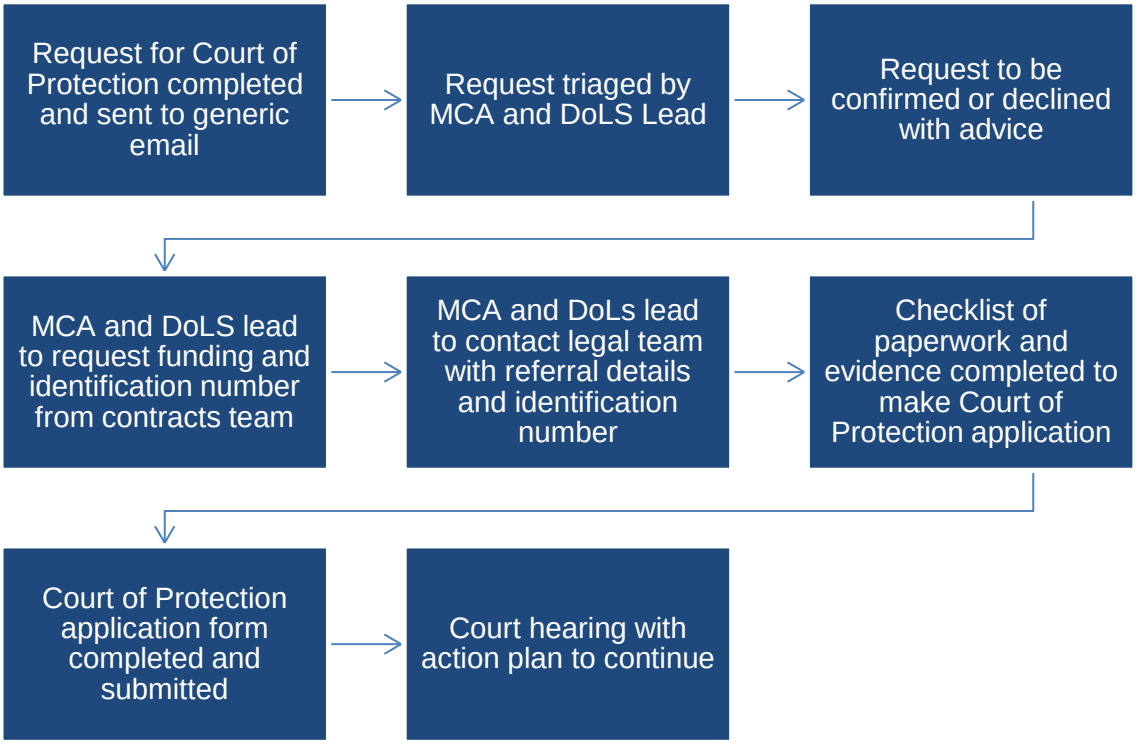


The flow chart above describes the following steps that need to be followed:

1. Applies to those who are presently subject to a DoLS authorisation and are appealing this outcome.
2. Capacity assessment in relation to the decision being appealed.
3. Evidence of previous best interest discussion and meeting must be provided for consideration (following an appropriate framework of decision making).
4. Evidence of informal and formal mechanisms previously exhausted to resolve any difference or situation the court is being asked to rule on must be documented and provided.

Early conversation with the lead for MCA and Court of Protection must be had to alert NHS Kernow of the above activity. Once all the above have been exhausted and completed, then NHS Kernow will seek legal support to present the case to the Court of Protection.

Flowchart for Court of protection



The flow chart above describes the following steps that need to be followed.

1. Request for Court of Protection completed and sent to generic email: nhskernowccg.mentalcapacity@nhs.net.
2. Request triaged by MCA and DoLS lead.
3. Request to be confirmed or declined with advice.

4. MCA and DoLS lead to request funding and identification number from contracts team.
5. MCA and DoLS lead to contact legal team with referral details and identification number.
6. Checklist of paperwork and evidence completed to make Court of Protection application.
7. Court of Protection application form completed and submitted.
8. Court hearing with action plan to continue.

10. Supporting the person to make decisions

It is important to consider the following when supporting persons to make decisions:

- Does the person have all the information they need to make the decision?
- Have they been given information on all the alternatives available to them?
- How does the person communicate? People can communicate in a variety of ways, including non-verbal. Consider if they need an interpreter or specialist equipment/adapted information leaflet such as easy read.
- Have you considered what time of day is best for the person to make a decision?
- Is there a particular place where the person feels most comfortable?
- Would they like someone with them to support with this, such as a family member or carer or independent advocate?

It is essential not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person to understand.

What happens in an emergency?

In an emergency situation, urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies. However, even in emergency situations, healthcare staff should try to communicate with the person and keep them informed of what is happening.

11. When is a capacity assessment required?

The legal starting point is the presumption that an adult has mental capacity. Evidence to the contrary needs to be gathered to establish mental incapacity before decisions can be made and actions taken on behalf of the adult in best interest. It is also important that the person who does an assessment can justify their conclusions.

An assessment of capacity should be completed at any time where there is a concern that the person may not be able to make an informed decision. This may be at the point

when seeking consent for a non-invasive procedure like taking a person's blood pressure, or for an invasive treatment such as treatment of a pressure sore or insertion of a catheter. It is essential that staff appropriately assess capacity and evidence this for all decisions when it is felt that there is doubt regarding the person's capacity.

For significant decisions such as invasive treatments, with risk of side effects, it is advised that a formal assessment is completed using the assessment of capacity form (appendix 1). If you choose not to use any of the templates provided you must ensure you evidence your assessment and how the decision was reached. It is not acceptable to just record that a capacity assessment was completed and the outcome of this.

12. Who undertake the assessment of mental capacity?

The individual who assesses a person's capacity to make a decision will usually be the individual who is directly concerned with the decision and the person at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

More complex decisions may require more formal assessments. A professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist, nurse or social worker. However, 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 – not the professional, who is there to advise.

2 stage test of mental capacity

"A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help him to do so without success" (MCA 2005).

Mental capacity may fluctuate, and it is important to undertake the test at a time of optimal functioning, for example being sensitive to the effects of drugs. A person's mental capacity may be recovered with appropriate care and treatment, meaning that follow-up assessments may be required.

The test of mental capacity, as laid out in the MCA 2005, has 2 clear stages.

Stage 1

Does the person have an impairment or disturbance of the functioning of the mind or brain sufficient that the person lacks capacity to make that particular decision?

The impairment or disturbance of the functioning of the mind or brain, for example (this is not an exhaustive list):

- effects of alcohol or drugs

- all categories of mental illness including depression
- delirium
- head injury
- dementia
- learning disability
- brain injury

Stage 2

In order to establish the answer to the above question in stage 1, you must assess the following. Remembering CURB, can the patient:

1. Communicate their decision (whether by talking, using sign language or any other means). Ensure you make it clear how you have tried to promote communication.
2. Understand the information relevant to the decision (what is being proposed and why it is being suggested). This should be done in a simple and jargon freeway. The person needs to demonstrate they understand the salient points.
3. Retain the information (for long enough to process the information and make an effective decision).
4. Balance or weigh that information as part of the process of making the decision. Can they appreciate the benefits, risks, and alternatives of pursuing or not pursuing the option(s) suggested?

If all of the above are achieved, then the person must be regarded as having the mental capacity to make his or her own decision. It should be noted that the quality or reasonableness of the person's decision is not a factor. People have the right to make decisions that others may consider to be unwise.

If the person fails even one part of the test, then they must be regarded as lacking mental capacity for this specific decision. Health care staff must then ensure that they act in best interest.

13. Lack of capacity

Anybody who claims that a person lacks capacity should be able to provide proof. They need to be able to show, on the balance of probabilities, that the person lacks capacity to make a particular decision, at the time it needs to be made. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

Please use appendix 1.

14. What of a person cannot communicate?

Sometimes there is no way for a person to communicate. This will apply to very few people, but it does include:

- people who are unconscious or in a coma, or those with the very rare condition sometimes known as ‘locked-in’ syndrome who are conscious but cannot speak or move at all

If a person cannot communicate their decision in any way at all, the Act says they should be treated as if they are unable to make that decision.

15. Record keeping and professional liability

The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity to consent, provided that you:

- have observed the principles of the MCA
- have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question
- reasonably believe the action you have taken is in the best interests of the person

It is important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity, reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person’s best interests.

You can use the templates provided in appendix 1 and appendix 2 to record assessments of capacity and best interest decisions.

16. Best interest

When a person has been assessed as lacking capacity in relation to a specific decision, health and social care staff must ensure that any decision made on behalf of the person is made in best interest.

When making a best interest decision staff must consider the following areas below.

Regaining capacity

It may be appropriate to delay the decision to allow further time for additional steps to be taken to restore the person’s capacity or to provide support and assistance which would enable the person to make the decision themselves.

Encouraging participation

The person must be permitted and encouraged to participate as fully as possible in any act done for him or her and any decision affecting him or her. Time must be taken to try to seek their views. A trusted relative or friend, or an independent mental capacity advocate (IMCA), may be able to help the person to express wishes or aspirations or to indicate a choice between different options.

The person's feelings and wishes

The person making the decision must consider so far as is reasonably ascertainable, the person's past and present wishes and feelings; the beliefs and values that would be likely to influence their decision if they had capacity; and the other factors that they would be likely to consider if they were able to do so. This also includes specific views that may have been set out in an advance directive, communicated informally to relatives and carers or formally in the lasting power of attorney.

The views of other people

The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; anyone engaged in caring for the person or interested in their welfare; anyone that is a lasting power of attorney. You may also need to consult with other professionals involved in the person's care.

Do not make assumptions

The individual making the decision must not make any assumptions about the person based on age, condition, appearance or behaviour.

Please use appendix 2.

17. Who is the decision maker?

Under the Mental Capacity Act 2005, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves.

It is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity. Decisions relating to a person's social care needs may need to be made by a social worker, however, a decision relating to a person's treatment would be made by the person prescribing that treatment. For example, a pressure sore or insulin injection would be made by the clinician prescribing the insulin or dressing at that time. The person delivering the treatment would need to ensure that it remains in the person's best interest at the time of delivery. Equally a decision relating to a person's ability to consent to an emergency hospital admission may need to be made by a paramedic or GP.

The table below is an indicative guide how a response should relate to the level of complexity of the decision to be made.

Decision level	Decision maker	Recording
Simple: Informal day to day decisions such as what to wear, eat, where to go.	Formal carers in consultation with the person, their family, and friends.	Brief notes in care log record. Record any decisions the person is able to make for themselves, and what is known about their likes or dislikes.
Complex: Withdrawal or refusal of serious medical treatment	GP, NHS consultant or doctor or consultant nurse who knows the person best and who can provide information about the risks and choices in consultation with the person, their family, and friends	Record decision and rationale in medical records.
Complex: Permanent change of accommodation, for example going into residential care for 8 weeks or more	Case worker or CHC team manager who knows the person best and is able to offer the options or choices in consultation with the person, their family, and friends	Record capacity assessment and best interest decision and rationale in case notes

If a lasting power of attorney (or enduring power of attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority. Enduring powers of attorney predate the Mental Capacity Act 2005 and will still carry legal status but were only applicable to financial decisions.

18. What should I do if there is a dispute about best interests?

Family and friends may not always agree about what is in the best interests of an individual. If you are the decision-maker, you will need to clearly demonstrate in your record keeping that you have made a decision based on all available evidence and taken into account all the conflicting views.

If there is a dispute, the following things might assist you in determining what is in the person's best interests:

- get a second opinion

- hold a formal or informal case conference
- go to mediation
- seek advice from MCA lead who may then seek legal advice and make an application to the court of protection for a ruling
- seek legal advice in urgent circumstances
- an application could be made to the Court of Protection for a ruling

19. Independent mental capacity advocate

An IMCA is a specific type of advocate that has to be involved if there is no-one appropriate who can be consulted. An IMCA is not the decision-maker, but the decision-maker has a duty to take into account the information given by the IMCA.

An IMCA will only be involved if:

- the decision is about serious medical treatment provided by the NHS
- it is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home,
- a long-term move (8 weeks or more) to different accommodation is being considered, for example, to a different hospital or care home

An IMCA may also be instructed on behalf of a person lacking capacity for:

- care reviews, where no-one else is available to be consulted
- safeguarding adult cases, whether family or friends are involved

Duties of the IMCA include:

- supporting the person who lacks capacity and represent their views and interests to the decision-maker
- obtain and evaluate information
- as far as possible, ascertain the person's wishes and feelings, beliefs and values
- ascertain alternative courses of action
- obtain a further medical opinion, if necessary; and prepare a report for the person who instructed them
- if an IMCA disagrees with the decision made, they can also challenge the decision-maker

If you have any questions about IMCA services in Cornwall please contact The Advocacy People. Telephone: 0330 440 9000 or email The Advocacy People.

20. Governance

Governance of the safeguarding process is defined in the NHS England NHS EI Accountability and Assurance Framework 2019.

The CCG is accountable for all duties and responsibilities through its governing body.

These duties are described in the NHS Kernow safeguarding accountability and assurance framework.

The quality committee is a subcommittee of the CCG's governing body. The role of the quality committee is to ensure systems are in place to monitor and improve the safety and quality of healthcare commissioned by the CCG and that any areas of concern are addressed. In relation to the MCA and DoLS, it is the role of the committee to ensure that standards are integrated into the organisation's objectives and strategies. The committee meets once every 2 months, and minutes are presented to the governing body.

The reporting and recommendations to the quality committee are prepared through the CCG safeguarding assurance meeting. The safeguarding assurance meeting is a subcommittee of the NHS Kernow quality committee. The safeguarding assurance meeting is also the route of escalation to the quality committee.

MCA and DoLS expertise are also provided to the primary care committee, enabling triangulation of information and escalation to the quality committee if required.

21. Quality assurance and monitoring

Where review is necessary due to legislative change, this will happen as soon as practicably possible.

NHS Kernow has systems in place for quality assuring the safeguarding governance systems within provider organisations from which they directly commission services and this is set out in the NHS Kernow safeguarding accountability and assurance framework.

Contract leads and providers should raise concerns if they are concerned about compliance.

22. Update and review

All policies and similar documents must be dated when approved and a review date also included. This will usually be 3 years unless there is an indication to the contrary. It is the responsibility of the author (or nominated officer) to be aware of influencing factors and to initiate reviews promptly within the 3 years if appropriate.

23. Polices referred to in this document

- NHS Kernow safeguarding children policy
- NHS Kernow adult safeguarding policy

- Adult Safeguarding: Roles and Competencies for healthcare staff (2018) (Intercollegiate Document) (updated June 2020). Available at https://www.rcn.org.uk/professional-development/publications/pub-007069 [accessed 25/02/2021]
- Care Act 2014. Available at https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted [accessed 18/03/2021]
- Care and Support Statutory Guidance (2014). Available at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [accessed 25/02/2021]
- Cornwall and Isles of Scilly Adult Safeguarding Board Adult Safeguarding Policy Operational Procedure and General Guidance (2017). Available at https://www.cornwall.gov.uk/media/fvbknt32/adult-safeguarding-policy.pdf [accessed 25/02/2021]
- Human Rights Act 1998. Available at https://www.legislation.gov.uk/ukpga/1998/42/contents [accessed 18/03/2021]
- Mental Capacity Act (MCA) 2005. Available at https://www.legislation.gov.uk/ukpga/2005/9/contents [accessed 18/03/2021]
- NHS England (2015, updated 2019) Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework. Available at https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/ [accessed 18/03/2021]
- Office of the public guardian Mental Capacity Act Code of Practice available at Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk) [accessed 18/03/2022]

Appendix 1: Mental capacity assessment

Information required	Response
Full name of the person being assessed	
Date of birth (or estimated age if unknown)	
Name and address where the person may become deprived of their liberty	
Name and address of the assessor	
Profession of the assessor	
The present address of the person being assessed if different from the care home or hospital stated above	

Please provide any supporting information below:

Click or tap here to enter text.

What is the particular decision that needs to be made at this time?

Click or tap here to enter text.

Even if the person lacks capacity, can the decision be delayed until they regain capacity?

Click or tap here to enter text.

The following practicable steps have been taken to enable and support the person to participate in the decision-making process:

Click or tap here to enter text.

Stage 1

What is the impairment of, or disturbance in the functioning of the mind or brain?

Click or tap here to enter text.

Stage 2: Functional test

☐The person is unable to understand the information relevant to the decision

Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.

Click or tap here to enter text.

☐ The person is unable to retain the information relevant to the decision.

Record how you tested whether the person could retain the information and your findings. Note that a person's ability to retain the information for only a short period does not prevent them from being able to make the decision.

Click or tap here to enter text.

☐ The person is unable to use or weigh that information as part of the process of making the decision.

Record your findings about whether the person can communicate the decision

Click or tap here to enter text.

☐ The person is unable to communicate their decision (whether by talking, using sign language or any other means

Record your findings about whether the person can communicate the decision.

Click or tap here to enter text.

What does the Act mean by lack of capacity?

This means that a person lacks capacity if:

- they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works
- the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made

Please sign and date this form.

Signed: Click or tap here to enter text.
Date: Click or tap here to enter text.
Print name: Click or tap here to enter text.
Time: Click or tap here to enter text.
Job title: Click or tap here to enter text.
Base: Click or tap here to enter text.

Outcome of assessment

☐ On the balance of probabilities, I believe the person has capacity to make this decision.
☐ On the balance of probabilities, I believe the person lacks capacity to make this decision.

Based on the original ADASS template DoLs form 4, March 2015 V4 Final (May 2022 – accessibility updates to the form)

Appendix 2: Best interest meeting

Mental Capacity Act (2005)

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests: Principle 4 of the MCA.

Information required	Response
Meeting held on:	
Name:	
Address:	
Postcode:	
Chair of meeting:	
Decision maker:	

Name of participants	Designation or email

Confirmation of lack of capacity

Mental capacity record assessment attached and completed and those present or invited agree that the person lacks capacity to make the decision. In the event of anybody challenging the assessment result, and the disagreement cannot be resolved, then a second opinion or a ruling from the Court of Protection may be required. This will depend on the urgency of the decision to be made.

Date and place capacity assessment completed and by whom:

Click or tap here to enter text.

Regaining of capacity (is it likely that the person may regain capacity, can the decision wait until that time, if not why?

Click or tap here to enter text.

Is this the least restrictive option, if not why?

Click or tap here to enter text.

Justification for proposed care or treatment:

Click or tap here to enter text.

Risks relating to proposed care or treatment:

Click or tap here to enter text.

Risks related to not carrying out the proposed care or treatment:

Click or tap here to enter text.

What are the persons past and present wishes and feeling (these may have been expressed verbally, in writing, through behaviour or habits)?

Click or tap here to enter text.

Are there any beliefs and or values that would be likely to influence the decision, if the person had capacity? For example, religious, cultural, moral, or political.

Click or tap here to enter text.

What are the views of the other relevant people in the person's life? Is there a LPA for health, finances or welfare?

Click or tap here to enter text.

What are the views of the Mental Capacity Advocate (IMCA) (If involved)?

Click or tap here to enter text.

Is there a dispute about best interests?

Click or tap here to enter text.

Outcome of discussions; reasonable belief as to best interests:

Click or tap here to enter text.

Where the court is not involved, carers (unpaid), relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are working in the person's best interests. They must consider all relevant circumstances.

The undersigned believe this to be a fair and accurate representation of the discussions that took place. Those in attendance have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

Name: Click or tap here to enter text.
Designation: Click or tap here to enter text.
Signature: Click or tap here to enter text.

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Name: Click or tap here to enter text.
Designation: Click or tap here to enter text.
Signature: Click or tap here to enter text.

Appendix 3: Court of Protection triage tool

Triage for Court of Protection application

Question	Answer
Name of person and Broadcare number if known	
Name of person providing information and email address	
Funding stream in place or applied for (CHC, joint, section 117)	
Is the person already in placement or has a discharge plan to move to placement? Please give details	
Brief outline of background and level of restriction, for example 2:1, locked doors, restraint, medication	
What is the Court of Protection being asked to authorise?	
Family members, close friends or legal representative involved?	
Any previous Court of Protection involvement?	
Which commissioning manager has agreed to the Court of Protection proceedings?	

Notes and additional items

Reason or outcome required for Court of protection application:

Click or tap here to enter text.

Appendix 4: Checklist for documents required index

1. Consideration as to whether the application needs to be urgent
2. Medical evidence stating that “P” suffers from unsound mind.
3. Medical evidence that “P” lacks the capacity to consent to arrangements: Court of Protection.
4. Dated copy of “P’s” care or support plans from provider and agency.
5. Emergency or contingency care or support plan.
6. Statement of best interest: best interest meeting minutes.
7. An annex recording any relevant wishes and feelings expressed by “P.”
8. Additional court papers for evidencing LPA, EPA and deputy allocation.
9. Identified litigation friend or rule 3A representative.
10. Completed and signed application: Court of Protection 11.

Appendix 5: Glossary

Reference	Abbreviated term
Mental Capacity Act	MCA
Independent mental capacity advocate	IMCA
Lasting power of attorney	LPA
A personal welfare LPA is for decisions relating to health and personal welfare.	LPAHW
A property and affairs LPA is for decisions relating to financial matters.	LPAF
Enduring power of attorney	EPA
Deprivation of Liberty Safeguards	DoLs

Appendix 6: Impact assessment

Name of policy, service or decision to be assessed: MCA and DoLS policy
Department or section: Safeguarding and quality
Date of assessment: 25 May 2022
Person(s) responsible for the assessment: Charlotte Brown
Is this a new or existing policy? Existing

General background information

Reason for undertaking full impact assessment: Change to policy or procedure

Describe the aims, objectives and purpose of the policy, service change or development:
To ensure NHS Kernow has processes in place to comply with the Mental Capacity Act 2005 and to achieve the best outcomes for people protected by this act.

Anticipated timetable for decision: Less than 1 month

What areas will this impact? Cornwall and Isles of Scilly

Which of the strategic objectives apply to this full impact assessment? Other - improve care experience and improve health and well being

What are the commissioning arrangements? Other – cover whole of NHS Kernow in all aspects of practice

What are the contractual implications for the policy or service change? All staff and commissioned services should comply with this policy

Who implements the policy or service? NHS Kernow

Who benefits or is intended to benefit from this policy or service? All service users especially people who are unable to make decisions about their care and treatment or need support to do so. All staff will benefit from access to policy and guidance

What health and social care outcomes are achieved or wanted from this policy or service? Reducing health inequalities

How will this be monitored? Multiple sources

What factors or forces could contribute or detract from the outcomes? service pressure can affect impact

Who are the main stakeholders in relation to the policy or service? All staff and safeguarding partners

Is there clinical evidence for effectiveness of the policy or service? Yes - national

Does this policy or service link to health and social care overall strategy for the next 5 years and current direction of travel for integrated communities? Yes

Engagement

How have you engaged stakeholders in gathering or testing the evidence available? policy based on national findings from public enquiries and legislation and local system policy

What is the experience of individuals who access the service? Multiple – impact of the policy on safeguarding children is largely positive but due to the nature of the issues involved outcome can be mixed.

How have you engaged stakeholders in testing the policy or service proposals? Based on multi-agency policy which is developed by stakeholders

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Impacts

Access to services

Aspect	+ or – impact	Details and plans to minimise negative impact
Ability of people to access the service	positive	
Eligibility of people to receive the service	positive	
Longer term sustainability of the service	positive	
Reducing health inequalities	positive	
Waiting times to receive service	positive	

Quality of services

Aspect	+ or – impact	Details and plans to minimise negative impact
Choice for members of the public	positive	
Clinical performance or outcomes	positive	

Aspect	+ or – impact	Details and plans to minimise negative impact
Cohesion with wider services	positive	
Operational effectiveness	positive	
Statutory NHS targets	positive	

Members of the public and carers

Aspect	+ or – impact	Details and plans to minimise negative impact
Carer experience	positive	
Psychological	positive	
Privacy and dignity	positive	
Public care journey and pathway	positive	
Public care standards	positive	
Public experience	positive	
Public safety	positive	

Wider community

Aspect	+ or – impact	Details and plans to minimise negative impact
Cohesion with community strategy	positive	
Community safety, crime, and disorder	positive	
Environment, including climate change	positive	
Information management	positive	
Local economy	positive	
Rural isolation	positive	
Safeguarding*	positive	
Social care	positive	
Technology	positive	
Transport	positive	

* For safeguarding, consider the Care Act 2014 6 key principles: empowerment, prevention, proportionality, protection, partnership, and accountability.

Wider system partners

Has consideration been given to sharing with all appropriate meetings, groups or organisations?

Aspect	+ or – impact	Details and plans to minimise negative impact
Care homes	positive	
Cornwall Council	positive	
Cornwall Partnership NHS Foundation Trust	positive	
Council of the Isles of Scilly	positive	
Domiciliary care providers	positive	
E-zec Medical Transport	positive	
Hospice providers	positive	
Kernow Health CIC	positive	
NHS 111 (Vocare and Kernow Health CIC)	positive	
Out of hours primary care	positive	
Primary care	positive	
Royal Cornwall Hospitals NHS Trust	positive	
South Western Ambulance Service NHS Foundation Trust	positive	
University Hospitals Plymouth NHS Trust	positive	
Other system partners - please specify and add lines as necessary	positive	

Financial aspect

Aspect	+ or – impact	Details and plans to minimise negative impact
Implications for individual or carer	positive	
Implications for local authorities	positive	
Implications for NHS Kernow Clinical Commissioning Group	positive	
Implications for other NHS commissioning organisations	positive	
Implications for GP practice	positive	
Implications for primary care network (PCN)	positive	
Implications for surrounding practices	positive	
Implications for NHS provider organisations	positive	

Aspect	+ or – impact	Details and plans to minimise negative impact
Implications for peninsula	positive	
Implications for private sector	positive	
Implications for voluntary sector	positive	

Anticipated climate of opinion

Aspect	+ or – impact	Details and plans to minimise negative impact
Clinical opinion	No impact	
Colleagues	No impact	
Local community	No impact	
Media	No impact	
Political	No impact	

Protected characteristics

What is the differential impact on people from the perspective of race, nationality and/or ethnic origin? Does this have a positive or negative impact on people who have a black, Asian and minority ethnic (BAME) background? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of sex? Does this have a positive or negative impact on people who identify as male, female, or intersex? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of disability? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of sexual orientation? Does this have a positive or negative impact on people who identify as heterosexual, lesbian, gay, bisexual, pansexual, or asexual? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of age? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience. This policy is specifically aimed at protecting people who are protected by the Mental Capacity Act 2005 but can be applied in any care setting or environment.

What is the positive or negative differential impact on people from the perspective of religion or belief? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of marriage and civil partnership? This is particularly relevant for employment policies. How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of gender re-assignment? Does this have a positive or negative impact on people who identify as trans or transgender, non-binary or gender fluid? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of pregnancy and maternity? Does this have a positive or negative impact on people who are pregnant, breast feeding mothers, or those on maternity leave? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Other identified groups. How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Human rights

How have the core human rights values of fairness, respect, equality, dignity, and autonomy been considered in the formulation of this policy, service, or strategy? If they haven't, please review this document and amend to incorporate these values.

This in included in the content of the policy.

Which of the human rights articles does this document impact?

The right:

☒ to life
☒ not to be tortured or treated in an inhuman or degrading way
☒ to liberty and security
☒ to a fair trial
☒ to respect for home and family life, and correspondence
☒ to freedom of thought, conscience, and religion
☒ to freedom of expression
☒ to freedom of assembly and association
☒ to marry and found a family
☒ not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention
☒ to peaceful enjoyment of possessions

What existing evidence (either presumed or otherwise) do you have for this?

safeguarding is intrinsic to promoting human rights and ensuring prevention of discrimination and harm.

How will you ensure that those responsible for implementing the policy are aware of the human rights implications and equipped to deal with them?

Governance is in place to ensure the policy is embedded in practice and this includes promoting human rights

Social Value Act 2012

NHS Kernow is committed and obliged to fulfil the requirements of the public sector Social Value Act 2012. This act requires the organisations to consider how services commissioned or procured might improve the economic, social, and environmental wellbeing of an area. Please describe how this will support and contribute to the local system, wider system, and community.

Aspect	+ or – impact	Details and plans to minimise negative impact
Economic: promote skills, tackle worklessness, maintain employment, increase volunteer hours to support the community and promote inclusion	Positive	
Environmental: support local, reduce congestion	Not applicable	
Inclusion of small medium size enterprises (SMEs) in the process and supply chain	Not applicable	
Social: reduce anti-social behaviour, tackle exclusion by promoting inclusion including to vulnerable groups	Positive	

General public sector equality duties

Describe how the policy contributes towards eliminating discrimination, harassment, and victimisation.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Describe how the policy contributes towards advancing equality of opportunity.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Describe how the policy contributes towards promoting good relations between people with protected characteristics.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Any other impact not identified above?

No

Summary

If the differential impacts identified are positive, explain how this policy is legitimate positive action and will improve outcomes, services and/or the working environment for that group of people.

Promotion and adherence to this policy will ensure staff are confident to uphold the rights of those who are protected by the Mental Capacity Act 2005. This will be monitored via a robust governance structure.

Explain what amendments have been made to the policy or mitigating actions have been taken, and when they were made.

Updated to ensure take into account changes in practice and legislation.

If the negative impacts identified have been unable to be mitigated through amendment to the policy or other mitigating actions, explain what your next steps are using the following full impact assessment action plan.

None identified

Responsible person: Charlotte Brown and Rebecca Evans

Timescale for completion: 1 month

Issues to be addressed: Not applicable

Action required: Not applicable

Action taken: Not applicable

Comments: Not applicable

This impact assessment should accompany the policy or service change documentation through the sign off process.

Completed by: Charlotte Brown
Date: 25 May 2022

Agreed by (committee): Quality committee
Date: 31 May 2022