NHS Camden Clinical Commissioning Group

# Mental Capacity Act Policy

## Reference: QCE - PO -

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| 1 | **SUMMARY** | This policy describes the process for the coordination of arrangements to meet responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007, within NHS Camden Clinical Commissioning Group (CCG). It should be read in conjunction with the CCG Safeguarding Adults Policy and Pan- London Multi Agency Safeguarding Adults policy and procedure. |
| 2 | **RESPONSIBLE PERSON:** | Vikki Gray<br>Designated Nurse Safeguarding Adults |
| 3 | **ACCOUNTABLE DIRECTOR:** | Neeshma Shah<br>Director of Quality & Clinical Effectiveness |
| 4 | **APPLIES TO:** | All Camden Clinical Commissioning Group/Joint Commissioning staff. |
| 5 | **GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:** | Camden CCG Quality and Safety Committee |

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| **6** | **GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:** | Camden CCG Quality and Safety Committee | | | |
| **7** | **EQUALITY IMPACT ANALYSIS COMPLETED:** | **Policy Screened** | Statutory Responsibility | **Template completed** | |
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| **9** | **VERSION:** | 1.0 | | | |
| **10** | **AVAILABLE ON:** | **Intranet** | | **Website** | |
| **11** | **RELATED DOCUMENTS:** | Mental Capacity Act 2005- A guide for CCGs and other commissioners on Commissioning for compliance NHS England 2014<br><br>The Mental Capacity Act Code of Practice HM Government 2007<br><br>Deprivation of liberty safeguards-: putting them into practice. SCIE 2013<br><br>Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015<br><br>Human Rights Act 1998 HM Government | | | |
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| **12** | **DISSEMINATED TO:** | **All Staff on Camden CCG intranet** |
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**DOCUMENT CONTROL**

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## 1. Contents

## 2. Introduction

The Mental Capacity Act 2005 (MCA hereafter) embodies a legal framework to empower people to make decisions for themselves as much as possible and to protect people who may not be able to make some decisions.
http://www.legislation.gov.uk/ukpga/2005/9/contents

The Mental Capacity Act is vital to good quality and effective healthcare. The MCA is central to quality improvement and patient involvement. It gives rights to patients and provides essential safeguards to those that are vulnerable as well as setting out the responsibilities of those caring for them.

The MCA applies to anyone aged 16 or over in England and Wales with the exception of making a Lasting Power of Attorney, making a will or an advanced decision to refuse treatment; for these purposes a person must be 18 or over.

Capacity is unrelated to a person's age, gender, condition or any aspect of their behaviour. The MCA 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.

This policy is adapted from the Mental Capacity Act Statutory Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice for assessing whether people have the mental capacity to make decisions and procedures for making decisions on behalf of people when are assessed as lacking mental capacity.

## 3. Scope of this policy

This Policy applies to CCG staff, including interim staff and joint Commissioners. This policy sets out how, as a commissioning organisation, NHS Camden Clinical Commissioning Group (CCG hereafter) will fulfil its duties and responsibilities in relation to the Mental Capacity Act 2005 and deprivation of Liberty Safeguards 2009 (DoLS hereafter) effectively both within their own organisations and those it commissions including GPs and their practice staff.

The CCG, as members of the Camden Safeguarding Adult Board, formally adopts the principles of the Pan-London Multi-Agency Safeguarding Adult Policy and Procedures which includes the MCA and DoLS.

This policy assists staff in determining whether an individual lacks capacity, how to establish this, what action to take, how to make decisions when a person lacks capacity and when to involve an Independent Mental Capacity Advocate (IMCA).

CCGs have responsibility for commissioning high quality care and treatment. An essential element of this is ensuring providers of healthcare understand the MCA, apply it to practice and monitor compliance. The CCG must seek assurance that the MCA is embedded in the work of organisations with their patients.

The CCG will ensure that:

• The MCA is given a high profile and priority within the CCG

• Compliance and how this will be achieved informs the tendering and contract process

• Ongoing compliance is monitored in detail through performance review and quality monitoring processes

## 4. Monitoring and Reviewing

The Quality and Safety Committee of the CCG will agree a method for monitoring and disseminating this policy.

The Quality and Safety Committee will ensure this policy is reviewed in accordance with the timescale agreed at the time of approval on the understanding they will be informed of any changes that may affect the policy and timescale for review.

## 5. The Principles of the Mental Capacity Act 2005

The MCA is founded on five statutory principles:

• 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

• Support individuals to make their own decisions to make their own decisions – individuals must be given all appropriate support to make a decision before anyone concludes that they cannot

• 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 differ from others. A person cannot be found to lack capacity for that reason.

• Best interest – any decision made on behalf of a person without capacity must be in their best interests

• Less restrictive option – anything done for or on behalf of people without capacity should be the less restrictive option

The CCG will seek assurance that these principles are being applied in the delivery of the care they commission.

The purpose of this policy is not to provide a detailed guide to the Act however, a brief summary of the main provisions are:

• **Principles** – establishes five key principles shown in Section 4

• **Assessing capacity** – sets down a test for assessing whether a person lacks capacity to take a particular decision at a particular time – the test is decision and time specific rather than a global assessment of cognition. This includes whenever a care plan is being developed or reviewed at other relevant stages of the care planning process, and as particular decisions need to be made.

• **Best interests** – underlines the importance of best interests decision making and provides a non-exhaustive checklist of factors that decision-makers must work through when deciding what is in the best interests of a person assessed as lacking capacity.

• **Acts in connection with care and treatment** – offers a statutory protection from liability where a person is performing an act in connection with the care and treatment of someone

who lacks capacity assuming the decision is made within the framework provided by the Act.

• **Restraint** – the Act defines this and provides for the circumstances in which restraint can be used in relation to the care and treatment of somebody lacking capacity (in those circumstances where restriction and restraint may move towards deprivation of liberty the DoLS safeguards must be considered).

• **Future decision making** – the Act allows a person, while they have capacity, to plan ahead for a time when they may lack it through the appointment of a person(s) to take decisions in relation to property and affairs and/or health and welfare on their behalf.

• **Advance decisions** – the Act provides for patients a right to refuse treatment should they lose capacity in the future. It also provides for refusal of end of life treatment but such instructions must be in writing.

• **Court appointed deputies** – the Act allows the Court of Protection to appoint deputies on behalf of people lacking capacity to take decisions on welfare, healthcare and financial matters.

• **Court of Protection** – the Act created this Court which has jurisdiction relating to the whole of the Act.

• **Independent Mental Capacity Advocates (IMCAs)** – patients who lack the capacity to take decisions in relation to serious medical treatment, and have nobody to speak on their behalf, have a legal entitlement to an advocate (IMCA) who will bring to the attention of the decision maker information regarding the patient's wishes, feelings, beliefs and values as well as other factors which may be relevant to the decision.

• **Criminal offence** – the Act introduces a criminal offence of ill treatment or wilful neglect of a person who lacks capacity

• **Research** – the Act sets out parameters in relation to research involving those who may lack capacity.

Service providers should be familiar with all these provisions and have them embedded into their training, policies, governance and practice. The Act is supported by a Code of Practice which provides extensive guidance. Service providers should be familiar with the Code and must have regard to it.

## 6. Duties and Responsibilities

The Governing Body of the CCG is responsible for ensuring all commissioned services have arrangements in place to meet their statutory requirements and contract standards and that compliance is monitored. The Governing Body, through its governance structures, namely the Quality and Safety Committee, will assure itself commissioned services are compliant with MCA and DoLS requirements through safeguarding annual, quarterly and exception reports.

The Designated Nurse for Safeguarding Adults is the Designated Lead for MCA for the CCG, reporting to the Director of Quality and Clinical Effectiveness. The CCG is required

to have an MCA Lead who can provide expert support and guidance to the commissioning and contracts process and also advise clinicians on individual cases.

The MCA Lead should also have a role in the monitoring of compliance with the MCA in commissioned services and the wider system through partnership working with the Camden Safeguarding Adult Board (CSPB) and Camden Safeguarding Children Board (CSCB).

## 7. Member Practice Assurance

The CCG will be responsible for ensuring GP services, including those they commission, have effective arrangements for complying with the MCA. The CCG assurance process will demonstrate how it is satisfied that this duty is being discharged.

### 7.1 Governance

Evidence of the MCA featuring in audit programmes

• Evidence of the involvement of clinical governance processes in best interests decision-making through audit and reviews to evidence how the Code of Practice is being applied

• Board reports on the management and treatment of people lacking capacity.

• Information on how often and in what way the hospital seeks legal advice in relation to the Court of Protection and potential referrals to the Court

• Evidence that the MCA is linked into the provider systems and processes relating to improving service users' experience and the quality of their care and treatment.

• Copies of extracts from CQC reports relating to compliance with the MCA

• Evidence that legal advisors are familiar with the MCA, up to date with case law and are advising the service provider accordingly

### 7.2 Policy

Copies of service providers MCA policies

• Evidence that each provider has an MCA lead

• Written evidence of MCA-compliant capacity assessments and best interests' decision-making documentation and procedures

• Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning policies, guidance and training

• Evidence that the MCA is linked into the provider systems and processes relating to improving service users' experience and the quality of their care and treatment

• Any policies on research which recognise the rights of those lacking capacity

### 7.3 Training

Copy of the service provider's training, induction and refresher training policy

• Sight of summary reports on staff induction, training and refresher training records including attendance records

• Assurance that the MCA features in the job descriptions and personal development reviews of all staff working directly with patients

• Arrangements for training on restriction and restraint and associated recordkeeping

• CCGs will pay particular regard to restraint being proportionate to the harm that it seeks to prevent

• How MCA-related case law is explained to staff

• Evidence that staff are familiar with the Code of Practice and have easy access to it when seeking guidance

Assurance will be provided through safeguarding annual, quarterly and exception reports from providers. Issues with compliance will be addressed through quality and contract meetings and escalated where necessary through the Contract and Quality Review Group (CQRG).

## 8. Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act but were introduced at a later date coming into operation in April 2009. The safeguards apply to people who lack capacity to consent to their care and treatment in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty.

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 moves towards depriving that person of their liberty it could be unlawful unless authorised by the relevant local authority or court following an assessment process determined in law.

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*."

A Supreme Court Judgment known as 'Cheshire West' on 19 March 2014, made clear that liberty means the same for all, regardless of disabilities or conditions and the deprivation of that liberty, therefore, applies far wider than health and social care have previously recognised.

The 'Acid Test' was devised by the court to help identify a deprivation of liberty:

• Is this patient free to leave (whether they are compliant or not) AND

• is this patient subject to continuous supervision and control?

The CCG is aware that the Safeguards are applicable in settings where health care is delivered, including community settings such as supported living. There will be occasions when it will be necessary, in the best interests of an incapacitated patient, to deprive that person of their liberty. DoLS are a safeguard and a positive tool in that they provide independent scrutiny to ensure that such a situation is in the best interests of the individual concerned. It is an unauthorised deprivation of liberty, i.e. lacking the necessary scrutiny, which is unlawful.

As with the wider MCA, the CCG will seek assurance that the rights of the population on whose behalf it is commissioning services are protected in relation to the Safeguards. Assurance is required from providers that patients are not being deprived of their liberty unlawfully and that when service users require the protection the Safeguards offer they are in place.

Assurance will be provided through safeguarding annual, quarterly and exception reports from providers. Issues with compliance will be addressed through quality and contract meetings and escalated where necessary through the governance structure of the CCG.

### 8.1 Arrangements for Monitoring Compliance

There is a clear free standing section covering DoLS in provider's MCA policy or a separate policy but linked to the MCA policy.

• There is separate staff training on the safeguards.

• Guidance and training on care planning covers the importance of staff being aware of the safeguards in cases where restriction and restraint might be in the patient's best interests.

• Staff know how to access the various DoLS authorisation forms, have had training on their completion and know where they should be submitted.

• DoLS being included in audit and internal review work programmes

• Evidence that the hospital has established clear and effective working arrangements with its local authority DoLS team.

• Evidence the hospital is aware of responsibility to report DoLS authorisation applications and the outcome to the CQC

• Evidence the safeguards feature in reports relating to the care and treatment of vulnerable patients particularly those with dementia, a mental illness or learning disability, acquired brain injury and stroke

• Staff have access to the DoLS Code of Practice.

• Local legal advisors are familiar with the safeguards and are briefing the hospital on DoLS related case law.

Assurance will be provided through safeguarding annual, quarterly and exception reports from providers. Issues with compliance will be addressed through quality and contract meetings and escalated where necessary through CQRG meetings.

## 9. Children and Deprivation of Liberty

There is new and developing case law in respect of deprivation of liberty regarding children.

Parents can give consent for deprivation of liberty if it falls within the zone of parental responsibility. Deprivation of liberty can also be lawful if warranted under statute i.e. Section 25 of the Children Act 1989 secure accommodation provisions. http://www.legislation.gov.uk/ukpga/1989/41/section/25

Where a child is looked after by the Local Authority, different considerations apply even where the parents' consent to deprivation of liberty. Their consent may be adequate where this falls in the zone of parental responsibility but where the child is the subject of an Interim Care Order or Care Order it is unlikely a parent could consent, neither can the local authority.

Where there is a deprivation of liberty the local authority must either use a statutory route if Section 25 of the Children Act 1989 or the Mental Health Act 1983 is applicable, or approach the high court to invoke its inherent jurisdiction to make an order for deprivation of the child's liberty. Services commissioned by the CCG have a responsibility to keep abreast of the law to recognise and respond to actual and potential deprivations of liberty of children. Procedures for monitoring compliance of DoLS in Section 8.1 of this document also apply to children's cases.