South Tyneside
Clinical Commissioning Group

Deprivation of Liberty within a Domestic Setting

Ratified	Quality and Patient Safety
Status	Final
Issued	October 2016
Approved By	Quality and Patient Safety
Consultation	CCG Leads CCG Executive Committee CCG Quality, Patient and Safety Committee
Equality Impact Assessment	Completed
Distribution	All Staff
Date Amended following initial ratification	Non applicable
Implementation Date	April 2020
Planned Review Date	January 2022
Version	3.2
Author	Sarah Golightly, Joint Commissioning Manager – Learning Disabilities & Sharon Thompson Designated Nurse Safeguarding Adults
Reference No	CO10

Policy Validity Statement
This policy is due for review on the date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
V1	28/02/2013	PCT	Policy provided to CCG as part of standard policy suite
V2	15/03/2016	NECS Joint Commissioning Team	Policy reviewed and amended in light of guidance changes.
V3	14/10/2016	Sarah Golightly, Joint Commissioning Manager, Learning Disabilities, NECS	• Reviewed governance arrangements in line with the new combined MCA and DOLS policy. This policy is to give clarity to the issues of Domestic Deprivations of Liberty in STCCG. • Change of Title
V3.1	April 2020	Sharon Thompson, CCG Lead	No legislation update or impact on external environment factors. Extension request due to COVID19 priorities.
V3.2	April 2021	Joint Commissioning Unit, CCG	Extension for 12 months in light of COVID19

Approval

Role	Name	Date
Approval	Governing Body	28/02/2013
Approval	Quality, Patient & Safety Committee	17/02/2016
Approval	Quality, Patient & Safety Committee	05/10/2016
Approval	Director of Operations, CCG	April 2020
Approval	Virtual Executive Committee	April 2021

Review

This document will be reviewed at least two years from its issue date.

Contents

"The deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned.**"**

Deprivation of Liberty Safeguards: Code of Practice

1. Introduction

For the purposes of this policy, NHS South Tyneside Clinical Commissioning Groups will be referred to as "the CCGs".

This policy sets out how the CCGs will fulfil their duties and responsibilities effectively, both within their own organisations and across the local health economy via their commissioning arrangements in relation to the Deprivation of Liberty within a domestic setting and authorised via the Court of Protection (CoP)

The CCGs aspire to the highest standards of corporate behaviour and clinical competence to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, the public, staff, and other stakeholders, and in the use of public resources. In order to provide clear and consistent guidance, the CCGs will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The Deprivation of Liberty Safeguards (DoLS) provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed there under public or private arrangements. They are not available to those people at risk of a DoL within their own home or supported tenancy.

Any DoL must be only

- *in their own best interests to protect them from harm*
- *if it is a proportionate response to the likelihood and seriousness of the harm,*

And

- *if there is no less restrictive alternative*.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

This policy should be read in conjunction with the:

- The Mental Capacity Act: Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- CO03: MCA and DOLS Policy

The purpose of this policy is to support the CCGs in discharging their duties and responsibilities as a commissioner. This requires the CCGs to understand and be able to apply the principles of the Mental Capacity Act Code of Practice, so they can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests. Commissioned services are expected to demonstrate compliance with the code of practice and any legal changes as a result of case law.

This policy applies to all staff employed by the CCGs, including any agency, self-employed or temporary staff. All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

2. Definitions

2.1. The following terms are used in this document:

• Advance Decision to refuse treatment	ADRT
• Best Interests Assessor	BIA
• Court of Protection	CoP
• Deprivation of Liberty	DOL
• Enduring Power of Attorney	EPA
• General Practitioner	GP
• Independent Mental Capacity Advocate	IMCA
• Lasting Power of Attorney	LPA
• Managing Authority (Hospital)	MA
• Mental Capacity Act	IMCA
• Mental Health Act	MHA
• Office of the Public Guardian	OPG
• Relevant Persons Representative	PR
• Supervisory Body (LA)	SB
• North East Commissioning Support	NECS

2.2. Equality and Diversity Leads:

CCG Director of Operations

2.3. Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain. An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- A substance misuse

Lacking capacity is about the ability to make a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

3. Mental Capacity Act Principles

The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- the principles of the MCA have been observed
- an assessment of capacity has been carried out and it is reasonable to believe that the person lacks capacity in relation to the matter in questions
- it is reasonable to believe the action to be taken is in the best interests of the person

There are five key principles underpinning the MCA as follows:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not unable to make a decision unless all steps have been taken unsuccessfully.
- A person is not unable to make a decision merely because he makes an unwise decision.
- An act/decision made on behalf of a person who lacks capacity must be in his best interests.
- Before the act or decision, ensure it is achieved in the least restrictive way.

The Mental Capacity Act applies to all people over the age of 16, except when making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, a person must be aged 18 or over.

4. Deprivation of Liberty

A Deprivation of Liberty may occur in any care setting, the DoLS provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements but do not cover those DoL in a domestic setting.

The European Court of Human Rights has identified three elements that all need to be met before a particular set of circumstances will amount to a deprivation of liberty under Article 5:

- ✓ The objective element: that the person is confined to a particular restricted place for a non-negligible period of time
- ✓ The subjective element: that the person either does not or cannot consent
- ✓ Imputable to the state: that deprivation is one for which the state can be said to be responsible.

On 19th March 2014, the Supreme Court published its' judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases. This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an 'Acid Test'.

For a person to be deprived of their liberty, they must:

- lack capacity to consent to the relevant care and support arrangements
- be subject both to continuous supervision and control

And

- not be free to leave.

In all cases the following are not relevant to the application of the test:

- The person's compliance or lack of objection to the care arrangements.
- The reason or purpose behind a particular placement; and
- The relative normality of the placement (whatever the comparison made). This means that the person should not be compared with anyone else in determining whether there is a Deprivation of Liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities).

The introduction of the 'Acid Test' has reduced the threshold and widened the scope of who may be affected to include Independent Living Schemes, Adult Placements, Children's Foster Placements and people at home receiving funded packages of care.

This test is far broader than those set by previous judgements - disabled people should not face a tougher standard for being deprived of their liberty than non-disabled people.

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This can include a placement in a supported living arrangement in the community or in the person's own home. These must be authorised by the Court of Protection.

5. Application of guidelines

These guidelines are relevant to people who receive commissioned support within a setting other than a hospital or care home, and whose care arrangements may amount to a deprivation of their liberty. The guidelines specifically apply to those individuals who have a mental disorder (as defined by the Mental Health Act 1983) and lack capacity to consent to the arrangements made for their care and treatment and where the circumstances of that care and treatment may amount to a deprivation of liberty.

Consideration of a Potential DoL within supported living services, shared lives schemes (formerly known as adult placements) and extra care housing requires an integrated health and social care approach. Whilst a package of care that amounts to a DoL within a domestic setting may be commissioned by the CCG, the arrangements and oversight of that care are not uncommonly given by the North East Commissioning support unit (NECS) and / or the Local Authority (LA).

5.1 Overview of Process

When the case manager assisting in identification of the health outcomes develops the support plan in conjunction with the individual (and their family if appropriate), they must also consider whether the plan results in the individual being deprived of their liberty. If following discussion it is felt that this maybe the case, then there is a responsibility to take all reasonable steps to consider whether the support plan can be amended to reduce the level of restrictions so that a deprivation is not occurring.

If this is not possible then the CCG will need to be notified so that they can make a decision, in line with their responsibility as commissioner, on the appropriateness of a referral to the Court of Protection. Dependent on the circumstances of the individual person DoL, agreement on which organisation, (NECS, CCG, LA) takes the application forward will need to be discussed on an individual case-by-case basis and clarity should be sought locally.

Due to the high probability that there will be commissioned cases where individuals are already having their liberty deprived in the their own home/supported tenancy, then CHC teams need to ensure that there is a clear process on review in place to identify potential cases so that the relevant CCG is made aware.

5.2 What is a supported living service?

The generic term, ‘supported living’, describes a form of domiciliary care whereby a CCG or local authority arranges a package of care and accommodation to be provided to a disabled, elderly or ill person. The individual lives in their own (often rented) home and typically receives social care and/or support to enable them to be as autonomous and independent as possible. The provision of accommodation is thereby separated from the delivery of care at an organisational level. There is usually some form of tenancy or licence arrangement with a landlord attracting housing benefit, with means-tested tailored support being provided by a distinct care provider with activities of daily living, education, training, employment and social interaction. The care setting is therefore not likely to constitute a “care home” for registration purposes.

Supported living services need only be registered with the Care Quality Commission (CQC) if they carry on a regulated activity that is nursing or personal care. If, for example, the individual is supported with cleaning, cooking and shopping, or is supervised to take prescribed medicine, the service does not require registration. If personal care is being provided but not in the place where they are living, for example at day services, then registration of the service is not required. However, where nursing or personal care is provided to those, for example, with more complex needs, then such care will need to be a regulated activity requiring CQC registration. The Care Act 2014 adopts the definition of nursing and personal care presently provided for in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

“nursing care” means any services provided by a nurse and involving:

(a) the provision of care; or
(b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a nurse;

“personal care” means:
(a) physical assistance given to a person in connection with:
(i) eating or drinking (including the administration of parenteral nutrition),
(ii) toileting (including in relation to the process of menstruation),
(iii) washing or bathing,
(iv) dressing,
(v) oral care, or
(vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.”

Such regulated activities do not apply to the provision of accommodation to someone by a carer under a shared lives scheme (see below), school, or a further education institution.

5.3. Supported living: liberty-restricting measures

The following are measures which may be found in the specific features of this care setting:

- Decision on where to live being taken by others;
- Decision on contact with others not being taken by the individual;
- Doors of the property locked, and/or chained, and/or bolted for security reasons or to prevent residents leaving;
- Access to the community being limited by staff availability;
- A member or members of staff accompanying a resident to access the community to support and meet their care needs;
- Mechanical restraint, such as wheelchairs with a lapstrap or harness (e.g. Crelling), reinforced glass in mobility vehicles, protective helmets;
- Varying levels of staffing and frequency of observation by staff;
- Restricted access to finances, with money being controlled by staff or welfare benefits appointee;
- Restricted access to personal items to prevent harm;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks;
- Chemical restraint, such as medication with a sedative or tranquilising effect;
- Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds;
- Restricted access to modes of social communication, such as internet, landline or mobile telephone, correspondence;
- Positive behavioural reward systems, to reward “good” behaviour;
- Restricted access to family, depending on level of risk and availability of staff and resources;
- Lack of flexibility, in terms of having activities timetabled, set meal times, expected sleep times

5.4. What are Shared Lives schemes?

These schemes, formerly known as adult placements, differ from supported living arrangements as they involve the individual being placed in a family setting. They are likened to adult fostering arrangements and are available to those aged 16 and over. Usually a local authority arranges for the person to receive day support, short breaks or respite, or long term care in the family home of a Shared Lives carer so as to enable them to share the family life, social life and community activities. The schemes are designed for those wanting to live independently but not on their own. The majority of those receiving such care have learning disabilities, although the scheme extends to those with physical disabilities, mental health issues or drug or alcohol problems. Shared Lives carers are self-employed, with rates of payment set by the local authority or the scheme itself according to the location and the person’s level of need. Carers receive payments to cover some of their time, rent and a contribution towards the household running costs.

Although accommodation is often provided together with personal care, it is not required to be registered as a “care home”. But Shared Lives schemes are regulated under the Health and Social Care Act 2008. The schemes approve and train the carer, receive referrals (typically from the local authority), match the needs of the person with the carer, and monitor the arrangements. A maximum of three people (two in Wales) can be supported by the carer at any one time and carers do not employ staff.

5.5. Shared Lives schemes: liberty-restricting measures

The following are measures which may be found in the specific features of this care setting:

- Varying levels of supervision and guidance with activities of daily living;
- Encouraging participation in family and community activities;
- Preventing the person from leaving unaccompanied for their immediate safety;
- Ensuring behavioural boundaries;
- Conveying the person to health and other appointments;
- Addressing challenging behaviour;
- Assist with medication, including sedative effect.

5.6. Extra care housing

Extra care housing represents a hybrid between living at home and living in residential care. Usually purpose built, self-contained properties on a single site, schemes provide access to 24-hour domiciliary care and support and community resources. Their models differ from assistive technology in someone’s own home to retirement and care villages to, for example, specialist dedicated schemes for those with dementia. Unlike residential care, those in extra care housing usually rent, purchase, or share ownership of typically a one or two-bedroomed apartment or bungalow in the housing scheme or care village and do not receive one-to-one care. Unlike living in one’s own home, those in extra care housing will have 24-hour access to personal care with progressive degrees of privacy, dependent upon their level of need.

Some individuals will have a domiciliary carer. A warden is also usually on site to check on the welfare of residents. For the larger schemes, there are also on-site facilities and social care services usually available for those requiring daily support. These can include on-site care teams, rehabilitation services, day centre activities, restaurants, laundrettes, hairdressing and beauty suites, and possibly shops, cinemas, gyms, even the garden shed. Moving into extra care housing may be a lifestyle choice. Or it may be necessary due to an individual’s level of social and/or health care need. The decision to move in may or may not be made at a time when the individual had mental capacity, or their mental functioning may deteriorate subsequently, with it no longer being safe for them to go out unaccompanied. It is therefore a common occurrence for those in extra care housing to not be free to access the community but the intensity of care measures varies enormously.

5.7. Extra care housing: liberty-restricting measures

The following are measures which may be found in the specific features of this care setting:

- Location devices;
- Door sensors to raise to alert staff to the person's exit from their property;
- Movement sensors to raise alert staff to the person's movements within their property;
- Verbal or physical distraction techniques used, for example, to dissuade the person from going out unaccompanied;

5.8. Within their own home

This could be a home that they own or rent themselves, or a home owned or rented by a family member or members with whom they live.

5.9. The home environment: liberty restricting measures

Almost by definition, arrangements made at home will be more varied and more flexible than arrangements made in any institutional or quasi-institutional setting. It is also more likely that, because the arrangements are likely to be more tailored to the individual, they will less obviously be directed to the control of that individual in the interests of others within a placement (whether other service users or the staff).

It is important to remember that MIG was found to be deprived of her liberty in an adult foster placement – i.e. a home-like environment – in circumstances where the supervision and control to which she was subject was *"intensive support in most aspects of daily living,"* even though she attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

The following features may constitute liberty-restricting measures in the home environment:

- The prescription and administration of medication to control the individual's behaviour, including on an as required basis;
- The provision of physical support with the majority of aspects of daily living, especially where that support is provided according to a timetable set not by the individual but by others;
- The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);
- The regular use of restraint by family members or professional carers which should always be recorded.in the individual's care plan;
- The door being locked, and where the individual does not have the key (or the number to a key pad) and is unable to come and go as they please, strongly suggests that they are not free to leave;
- The individual regularly being locked in their room (or in an area of the house) or otherwise prevented from moving freely about the house.
- Use of medication to sedate or manage behaviour, including PRN

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorisation must be obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), the Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (CoP). The CCGs should be able to seek assurance from commissioned services that they are compliant with the DoLS framework and CoP requirements. This includes providers of Continuing Health Care Services (CHC) and NHS Funded Care.

As Supervisory Bodies, local authorities have established MCA DoLs policies and procedures which clearly outline expectations of NHS hospital providers and care homes, as Managing Authorities (MA) to apply for a DoLS.

Any unauthorised deprivations carry with it a potential risk of litigation. If a CCG identifies via its commissioned services that such a risk exists, this should be included on the risk register and an action plan to address the risk developed and reviewed in accordance with the CCG Risk management arrangements.

6. Governance and Accountability

The CCG Governing Body is responsible for making certain all its provider services have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. Provider management will seek assurance via the local quality requirements. The governing body through its governance structures namely the Designated and Name Safeguarding Assurance group, will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DOLs

- Quarterly
- Annual report

The CCG will ensure effective leadership, commissioning and governance through the following:

Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and that STCCG commissioning, contracting, contract monitoring and quality assurance processes fully reflects this. MCA and DoLS is an agenda item within Safeguarding, on the provider services' Clinical Quality Review Groups (CQRGs) in accordance with the CQRG Forward Plan.

Ensuring service specifications, invitations to tender and service contracts fully reflect MCA and MCA DoLS requirements as outlined in this policy with specific reference to the clear standards for service delivery.
Ensuring a system is in place for escalating risks via Risk Registers and CQRGs.

6.1 Service Contract Standards

Clear service standards for ensuring compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) will be included in NHS commissioned services contracts, as appropriate to the service.

The CCG will seek assurance from providers in relation to these standards via its contract management and quality assurance processes.

7. Duties and Responsibilities

7.1 Governing Body (GB)

The CCG has delegated responsibility to the Governing Body for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.

7.2 The Chief Officer

The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.

The Chief Officer is accountable for ensuring that the health contribution to MCA and DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements.

This role is supported by the Clinical Director for Mental Health and Learning Disability who is board lead for MCA who is supported by the Safeguarding Leads for expert advice to the Governing Body on MCA and MCA DoLS matters.

7.3 The Clinical Director for Mental Health and Learning Disability (MH&LD)

The CCG Clinical Director for MH&LD as Executive Lead for MCA and DoLS will, with support from the Mental Capacity Practice Development Lead ensure STCCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a program of training and mentoring to support staff within the CCG. The Clinical Director for MH&LD is the Sponsoring Director for this policy and is responsible for ensuring that:

This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
The necessary training required to implement this document is identified and resourced.
Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.
The CCG has in place assurance processes to ensure compliance with MC and DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers

7.3 Mental Capacity Practice Development Lead

The MCA Practice Development Lead will support the Executive Lead on aspects of the NHS contribution to MCA and DoLS across the CCG's area, which includes all commissioned providers. The post will:

Work with the Clinical Director of MH & LD to ensure robust assurance arrangements are in place within the CCGs and provider services.

Provide advice and expertise to the CCG's governing bodies and associated groups and to professionals across both the NHS and partner agencies.

Provide professional leadership, advice and support to lead professionals across provider trusts/services and independent contractors.

Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, DoLS.

Lead and support the development of MCA, DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.

- Provide advice and guidance in relation to MCA, DoLS training including standards.
- Ensure quality standards for MCA, DoLS are developed and included in all provider contracts and compliance is evidenced.
- Work closely with the Designated Professionals for Safeguarding Children and Safeguarding Adults to ensure that where appropriate there is effective information flow across both adults and children's safeguarding services.

7.4 Designated Leads for Safeguarding Adults

The Designated Lead for Safeguarding Adults will provide oversight and support to the work of the MCA Practice Development Lead. They will provide leadership to ensure that MCA and DoLS is embedded in the Safeguarding and Quality strategy across the health economy. They will raise the profile of the Mental Capacity Act [MCA] and the Deprivation of Liberty Safeguards [DoLS] to ensure they are understood and effectively implemented in our local health services.

7.5 Managers and Executive Leads

Managers and Executive leads have responsibility for:

- Ensuring they are aware of and carry their responsibilities in relation to MCA, DoLS.
- Ensure that the MCA and DoLS policy is implemented in their area of practice.
- Ensuring staff are aware of the contact details of the MCA Practice Development Lead /professional and CCG Safeguarding Team for any issues of concern regarding care or commissioning practice relating to the MCA & DoLS.
- Ensuring that all CCG staff undertakes mandatory MCA, and DoLS training commensurate to their role as set out within the Safeguarding policy training section.

7.6 CCG Staff

All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:

- Comply with the MCA and DoLS Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.
- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager
- Complete mandatory MCA and DoLS training in accordance with the CCG MCA, DoLS Training Plan.

7.7 Commissioning Support Service (NECS)

The CCG commission, Continuing Health Care Services (CHC), adult safeguarding support services and Medicines Optimisation Services from the Commissioning Support Service. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSS will be expected to comply with the Service contract standards relating to MCA and DoLS.

7.8 Primary Medical Services (GP practices)

GP practices will be informed of the Service contract standards and encouraged to take account of these. The CCG in partnership with NHS England and supported by the CSS will develop a programme to support and monitor their adoption, and implementation in GP practices.

8. Implementation

This policy will be available to all Staff within the CCG via the shared intranet and the internet sites.

All Executive leads and Managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties.

8.1 Training Implications

The training required for CCG staff to comply with this policy are:

- Mandatory, MCA, including DoLS as set out within the training matrix of the Safeguarding Adults policy.

http://www.southtynesideccg.nhs.uk/wp-content/uploads/2015/11/CO16-Safeguarding-Adults-Policy-2.pdf

8.2 Documentation

8.2.1 Other related policy documents:

- Guidance on Advance Decision to Refuse Treatment (ADRT)
- Safeguarding Adults Policy

8.2.2 Legislation and statutory requirements

- Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.
- Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- Cabinet Office (1983) *Mental Health Act 1983*. London. HMSO
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO
- Department of Health (2007) Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. London. DH.
- Department of Health (2009) The Mental Capacity Act Deprivation of Liberty Safeguards. London. DH.
- Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office
- P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190

8.2.3 Best practice recommendations

- Department of Health. (2006) Records Management: NHS Code of Practice. London: DH.
- Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

9. Monitoring, Review and Archiving

9.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

9.2 Review

9.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

9.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

9.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

9.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice for Health and Social Care 2016.

10. Equality Analysis

A Full Equality Impact Assessment has been completed:

Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	Sharon Thompson
Title of service/policy/process:	Mental Capacity Act and Deprivation Of Liberty Safeguards Policy

Existing: □ **New/proposed:** □ **Changed:** √

What are the intended outcomes of this policy/service/process? Include outline of objectives and aims

This policy sets out how as a commissioning organisation South Tyneside Clinical Commissioning Group (STCCG) will fulfil its duties and responsibilities effectively both within its own organisation and across the local health economy via its commissioning arrangements in relation to the Mental Capacity Act (MCA) 2005 Commissioners must understand the implications of the MCA and DoLS, and STCCG commissioned services must demonstrate compliance with the MCA and as appropriate compliance with DoLS.

Who will be affected by this policy/service /process? (please tick)

√ **Consultants** √ **Nurses** √ **Doctors**
√ **Staff members** √ **Patients** □ **Public**
√ **Other**

If other please state:

Legal delegate consents such as LPA or appointees

What is your source of feedback/existing evidence? (please tick)

√ **National Reports** □ **Internal Audits**
□ **Patient Surveys** □ **Staff Surveys** □ **Complaints/Incidents**
□ **Focus Groups** □ **Stakeholder groups** □**Previous EIAs**
√ **Other**

If other please state:
Legislation/ Acts of Law

National Reports	**What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?)**
Patient Surveys	Mental Capacity Act 2006 and Deprivation of Liberty Safeguards 2009 House of Lords select committee report on above Acts March 2014 DoH response to recommendations on above. 'The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.' [HoL March 2014]
Staff Surveys	
Complaints and Incidents	
Results of consultations with different stakeholder groups – staff/local community groups	
Focus Groups	

STEP 2 - IMPACT ASSESSMENT
What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
Non – Policy to comply with Adult legislation 16 +
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
Set out commissioning and provider responsibilities regarding the MCA and DoLS. Human right based legislation to ensure principles of the MCA are maintained for all and in particular those with a mental impairment. Positive impact.
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.
Non – appropriate for all 16+
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
Non – appropriate for all 16+
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
Non – appropriate for all 16+
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
Non – appropriate for all 16+
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
Non – appropriate for all 16+
Sex/Gender A man or a woman.
Non – appropriate for all 16+
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Non – appropriate for all 16+
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
Non – appropriate for all 16+ Positive impact on rights set out within Acts
Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers
Non – appropriate for all 16+

STEP 3 - ENGAGEMENT AND INVOLVEMENT
How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?
No this is legislation based policy
Please list the stakeholders engaged:

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users of the policy?
□ **Verbal – stakeholder groups/meetings** □ **Verbal - Telephone** □ **Written – Letter** √ **Written – Leaflets/guidance booklets** □ **Email** √ **Internet** √ **Other**
If other please state: Disseminated to CCG staff via line management and referenced in training

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Tick to confirm you have you considered an agreed process for:
√**Sending out correspondence in alternative formats.** Easy read leaflets on DoLS- consulted with service users. □ **Sending out correspondence in alternative languages.** □ **Producing / obtaining information in alternative formats.** □ **Arranging / booking professional communication support.** □ **Booking / arranging longer appointments for patients / service users with communication needs.**
If any of the above have not been considered, please state the reason: This policy is primarily for staff to support their legal requirement to act within the legislation. Its target audience is not service users. Information on advocacy provided in alternative language by commissioned advocacy service to customers / service user

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1	There are no aspects of the policy that impact negatively on service users.

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?

SIGN OFF

Completed by:	**Sharon Thompson**
Date:	**4/07/2016**
Presented to: (appropriate committee)	**Quality and Safety Committee**
Publication date:	**2018**

Appendix 1

Individuals who lack capacity around a specific decision

1. Introduction

When a person is in your care and needs to make a decision you must assume that person has capacity and make every effort to support and encourage the person to make the decision themselves. This could include:

- Does the person have all relevant information?
- Could the information be explain or shown more easily?
- Are there particular times of the day when a person's understanding is better?
- Can anyone else help to support the person?

Also remember that people can make unwise or eccentric decisions, but this does not mean they lack capacity.

Every effort must be made to encourage and support a person to make a decision for themselves. If this is difficult, an Independent Mental Capacity Advocate (IMCA) is a service offering a specific type of advocate that will only be involved if there is no-one else appropriate and in specific situations.

When there is reason to believe a person does lack capacity at this time consider:

- Has everything been done to help and support the person?
- Does the decision need to be made without delay?
- Is it possible to wait until the person has the capacity to decide?

If the person's ability to make a decision still seems questionable then you will need to assess capacity.

2. Decision Making

The person responsible for undertaking the capacity test is the 'Decision Maker'**.** The person who assesses a person's capacity to make a decision will usually be the person who is directly concerned with that person at the time the decision needs to be made. It should be the most appropriate person in relation to the type of decision involved. This means that different people will be involved in assessing a person's capacity at different times and for the CCG they will be a qualified professional as follows:

- Qualified Nurses
- Physiotherapists
- Occupational Therapists
- Other Allied Health Professionals
- GPs

However, if a person has a Lasting Power of Attorney or Court Deputy then that person would act as the decision maker within the remit of their legal powers. For example finance and property or health and welfare or both if stated.

It is important to consider the following:

- What is the Decision that needs to be made?
- Who will be involved generally?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?

You should consider the following prompts prior to decision making:

- The environment is appropriate where it is quiet and uninterrupted.
- The person has the relevant information and in a format that they can understand? Do not burden the person with more detail than necessary.
- Could it be explained in an easier way and do you need help from other people for example a Speech and Language Therapist or an Interpreter to help with any issue of communication?
- Is this the right moment or place to discuss this, does the person seem comfortable discussing this issue now?
- Can anyone else assist? Consult with family and other people who know the person well.
- Does the decision have to be made now? Try to choose the best time for the person and ensure that the effects of any medication or treatment are considered.
- Can this wait until the person has capacity if the loss is temporary?
- Be aware of cultural factors, which may have a bearing on the individual. Consider whether an advocate is required.
- Take it easy. Make one decision at a time.

You must always follow the five key principles of the MCA in any decision-making and assess at a person's best level of functioning for the decision to be taken.

The MCA states that "assessment of capacity to take day to day decisions or consent to care require no formal assessment procedures". However although day-to-day assessments of capacity may be informal, they should still be written down by staff. Therefore if an employee's decision is challenged, they must be able to describe why they had a reasonable belief of a lack of capacity. Therefore recording should always be inserted within a patient's case notes or care plan. In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear and recorded process.

3. Functional Capacity Test

When should capacity be assessed? This must be decision specific which means that:

- The assessment of capacity must be about a particular decision at a particular time – not a range of decisions
- If someone cannot make a complex decision, don't assume they cannot make a simple decision
- You cannot decide someone lacks capacity based on his or her appearance, age, condition or behaviour alone.

In order to decide a person has the mental capacity to make a decision you must decide whether there is an impairment or disturbance in the functioning of the person's brain – it does not matter if this is permanent or temporary.

If so the second question is does the impairment/disturbance make the person unable to make that particular decision? The person will be unable to make a particular decision after all appropriate help and support to make the decision has been given to them they cannot:

- Understand the information relevant to the decision including the likely consequences of making or not making the decision.
- Retain the information
- Use the information as part of the decision making process
- Communicate their decision by any means

An assessment must be made on the balance of probabilities and although more than likely the person does lack capacity you should be able to demonstrate in your records why you have come to that conclusion.

Sometimes your assessment may be challenged by another person acting for the individual such as a family member or advocate. Seek resolution in the following ways:

- Raise the matter with the person who made the assessment and check records.
- A second opinion may be useful.
- Involve an advocate
- Local complaints procedure.
- Mediation
- Case conference
- Ruling by Court of Protection

4. Best Interests Assessment

If a person has been assessed as lacking capacity to make that decision then the decision made for, or on behalf of, that person, must be made in his or her best interests. A best interest's decision must be objective; it is about what is in the person's best interests and not the best interests of the decision maker.

The decision maker must weigh up all the factors involved, consider the advantages and disadvantages of the proposals and determine which course of action is the least restrictive for the person involved. This includes consideration of restriction or deprivation of liberty.

By best interests we mean:

- The decision maker has considered all relevant circumstances, including any written statements made while the patient had capacity must also be taken into account and any other information relevant to this decision
- Equal consideration and non-discrimination - not to make an assumption that a decision is made merely on the basis of a person's age or condition,
- The decision maker has considered whether the person is likely to regain capacity – can the decision be put off until then?
- Permitting and encouraging participation - the person has been involved as fully as possible in the decision, with the appropriate means of communication or using other people to help the person participate in the decision making process. Healthcare professionals are therefore required to make enquiries of relatives, carers and friends of the patient. Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be taken into account if the person had capacity, and to take into account, if practicable and appropriate the views of people who have formally or informally been involved with, or named by, the incapacitated person.
- Special considerations for life sustaining treatment - the decision maker is NOT motivated by a desire to bring about the person's death.
- Taking into account the views of any IMCA or Attorney appointed by the person or the Court of Protection.
- Consider whether there is a less restrictive alternative or intervention that is in the person's best interests.

When determining someone's best interests you must be able to demonstrate:

- That you have carefully assessed any conflicting evidence and
- Provide clear, objective reasons as to why you are acting in the person's best interests.

As far as possible try to ascertain:

- Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care?
- If practicable and appropriate you must consult with, and take in to account, the views of the following:
    - A Nominated Person
    - Lasting Power of Attorney appointed
    - Enduring Power of Attorney appointed
    - Court Appointed Deputy
    - Other persons engaged in caring for, or interested in, the person.

A Best Interest Meeting will need to be arranged with the relevant consultees.

5. Challenging the Result of an Assessment of Capacity or Best Interests Decision

Your assessment of capacity may be challenged. It is important that everything you do is carefully documented.

It may be challenged in the following ways:

- Raised directly with you
- Request for a second opinion
- Involving an advocate – NOT an IMCA
- Complaints procedure
- Court of Protection

However every effort should be made to resolve disagreements as informally as possible. Of importance are the following:

- How robust is the risk assessment?
- Has everything been recorded?
- Degree of 'contentiousness' of best interest decision between those involved in the person's care, i.e. the level of disagreement by family or IMCA as to proposed course of action?
- Is there a possibility of conflict of interest between family members and person, e.g. over finances?
- Urgency with which decision needs to be made?
- Degree to which decision/intervention can be reversed (undone)? The more irreversible, the higher the level of consultation required. Potential risks to the person and implications if a decision is made, not made or not reversed, including where other dependents are involved (e.g. children)

The Code of Practice makes it clear that any dispute about the interests of a person who lacks capacity should be resolved in a quick and cost effective manner.

Where significant persons are involved in the person's life every effort should be made to consult with, and involve, them and arrive at an agreed decision provided this is felt to be in that person's best interests and meets their assessed social and/or medical needs.

Where agreement cannot be reached seek assistance from your line manager or a senior manager in this process, further meetings may be necessary including seeking legal advice.

If no agreement can be reached the family or carers have recourse to the CCG complaints procedures of the agencies involved.

Recourse to the Court of Protection should be the last resort if no agreement can be reached. The equality and diversity lead should be consulted at this stage.

Appendix 2

Identification of Deprivation of Liberty

Identifying a Deprivation of Liberty where the person is subject to 'continuous supervision and control, and is not free to leave'.

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS) provides protection for vulnerable people whose care or treatment arrangements might amount to a deprivation of their liberty and who lack the capacity to consent to those arrangements. The accommodation settings in which a person might be deemed to be deprived of their liberty include, but are not limited to, 'domestic settings' such as:

- Supported housing (where support is provided on a 24/7 basis)
- Shared lives and adult placement schemes
- Residential colleges
- The individual's own home

The 'acid test' for whether those arrangements amount to a deprivation of liberty is as follows:

- Is the individual subject to continuous supervision and control, and
- Is the individual NOT free to leave the placement, and
- Is the individual unable to consent to such arrangements

If the answer to all of the above questions is 'Yes', then the person is deprived of their liberty and authorisation must be sought for that to continue in each case. If the deprivation of liberty is occurring in a domestic setting as listed above then an application must be made to the Court of Protection for that to be authorised. A deprivation of liberty that does not have the appropriate authorisation will be unlawful.

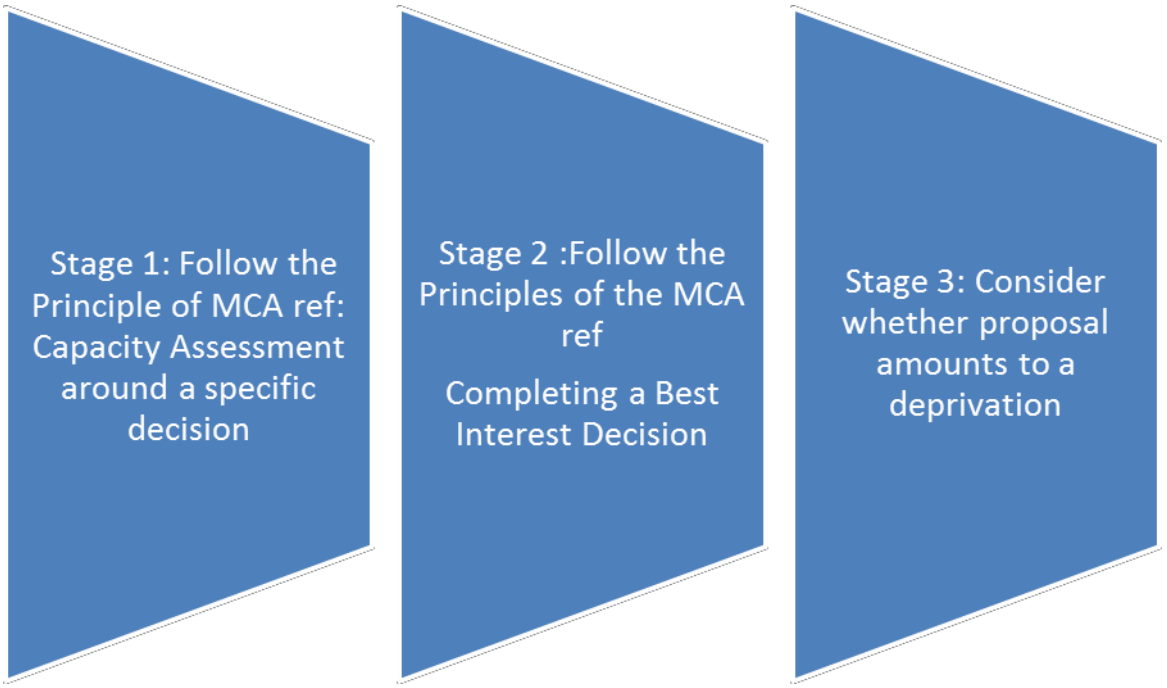
Appendix 3

DoLS Aide Memoire

NB. This **does not** replace Professional Responsibility to ensure that both the guidance within the Mental Capacity Act and the Deprivation of Liberty Act are followed.

Warning: This guide does not apply to individuals detained under the Mental Health Act 1983 (MHA), as amended by the MHA 2007, however may be used in parallel with the MHA in some individual cases – see Codes of Practice.

Three Stage Test – To aid practitioner to identify potential Domestic DoLS



Stage 1: Mental Capacity Assessment

Relevant Person's Name		Accommodation type	
Date of uptake of residence or admission		Date of current assessment or review	

Mental Capacity Assessment: Have regard to the 5 Statutory Principles of the MCA 2005
Test of Capacity (refer to Mental Capacity Act Section 2 & 3, and the Code of Practice Chapter 4)

Part One - Does the person have an impairment of, or a disturbance in, the functioning of mind or brain? **If no**, the person is deemed to have capacity by law. Stop the assessment at this point and seek advice from the care coordinator or a manager**. If yes**, include evidence below, then proceed to part two.	Yes / No
Evidence :	

Part Two - Does this impairment prevent the person from deciding to remain resident for the purpose of receiving care or treatment? Note: **This may require decision specific capacity assessments in relation to specific aspects of the care regime** and what this involves for the person. The 4 elements of the functional capacity test must be addressed below - does the person:			
1) Understand the information relevant to the decision?	Yes / No	2) Retain the information long enough to come to a decision?	Yes / No
3) Weigh the information in order to come to a decision?	Yes / No	4) Communicate their decision?	Yes / No
Evidence:			

Outcome of part two of the assessment: Does the relevant person have the capacity to consent to remain at the home/be admitted to the accommodation?	**YES:** the person **has capacity** If the answer to **all** of the questions in part 2 above is "Yes" the person has the capacity to make a decision reference his/her accommodation. Seek advice from the care coordinator or a manager NO: the relevant person lacks capacity If the answer to **any** of the questions in part 2 is "No" the person lacks the capacity to decide to remain in or move to the accommodation. Please continue with the Individual Scale Tool below.

Completed by:…… Date:……

Stage 2: Best Interest Decision

Please refer to chapter 5 of the Mental Capacity Act (MCA) Code of Practice – the statutory checklist - before completing a best interest decision. The person should be given every opportunity to be involved in the process.

Name of adult: Date of Birth: Person's first language: Name of decision maker(s): Job title / role(s): Date the decision was made:

Section 1: The decision to be made
Describe the decision that needs to be made: Be as specific and accurate as you can. **Note** – 1. A best interests decision can only be made once the person has been deemed to lack capacity for the decision in question 2. The decision should be delayed wherever appropriate – e.g. if it is likely the person will regain capacity

Section 2: People consulted as part of the decision making process

Note: A best interest meeting is not a statutory requirement. In many cases, alternative consultation methods e.g. email or telephone are likely to be more appropriate and time efficient.

Name:
Role / relationship to the person:
Contact details (where appropriate):

Name:
Role / relationship to the person:
Contact details (where appropriate):

Name:
Role / relationship to the person:
Contact details (where appropriate):

Add additional names where required

Section 3: IMCA Instruction

If an Independent Mental Capacity Advocate (IMCA) has been instructed, summarise their involvement below:
Full name of IMCA and email/contact details:

IMCA's views:

Section 4: Options available in relation to the decision

List all of the options available to the person

Section 5: Gathering Information

In each case you should list the name and role of the person providing the information.

(i) What are the person's past and/or present wishes or feelings relating to the decision?

(ii) What are the person's values and/or beliefs that relate to the decision (including cultural or religious considerations)

(iii) Are there any other factors that **the person** would want to be considered as part of the decision making process

(iv) What are the risks and benefits of each option?

(iv) What other factors that should be considered – for example: future implications of the decision (welfare, social and medical); safety concerns relating to specific options or how restrictive each choice might be.

Section 6: The decision reached in the person's best interests

Clearly state the decision reached and explain your rationale for it:

Disagreement: If there is disagreement consider the options outlined in the MCA Code of Practice:

- Involve an advocate
- Hold a case conference/best interests meeting if this has not already been done
- Get a second opinion or attempt some form of mediation
- Pursue a complaint through the organisation's formal procedures
- Consider whether it is necessary to approach the Court of Protection for a decision where all other attempts to resolve the disagreement have failed

Section 7: Review
Describe any circumstances in which a review of the decision would be necessary: Date of review (if required): Signature of decision maker(s): Date: Based at: Contact telephone number: Email address:

This section has purposefully been left blank for your notes. You might wish to include a summary of one or all of the following points:

- The best interest meeting discussion, including any balance sheets used and/or the views of absent parties
- An outline of the capacity assessment (main evidence/views)
- Any disadvantages which are inherent in the decision made and how any risks will be mitigated
- Any restrictions that might be needed in order to implement the decision
- Who will talk to the client about the outcome

Best Interests form: Guidance for decision makers
Deciding who the decision maker should be:

The Act is not prescriptive about who the decision maker should be. It is the person or organisation concerned with the Act of care of treatment at the time that must satisfy themselves about the individual's capacity and, where relevant, best interests. The Code of Practice provides a list of factors to consider when deciding who should adopt this role (5.8) and in practice this means that a range of decision makers might be involved with a person who lacks capacity depending on the decision to be made.

As a general rule, the person who will be carrying out/implementing the decision should be the person to make the decision.

In some instances it might be appropriate for the decision to be made jointly by, for example, a multi-disciplinary team. It is important to consider if there is someone, or something, already in place that might have the legal power to make the decision.

See the table below as a guide:

Advanced Decision to Refuse Treatment {ADRT}	If a valid and applicable decision to refuse treatment has been made, it cannot be overruled. Doubts about validity must be determined by the Court of Protection
Registered Lasting Power of Attorney – Personal Welfare	Unless restrictions or conditions have been added, the attorney/s can make decisions in the person's best interests about residence, contact, day-to-day care, medical treatment, care packages, social or educational activities, correspondence and papers, access to personal information and complaints
Registered Enduring Power of Attorney or Registered Lasting Power of Attorney – Property and Affairs	Unless specifically restricted, the attorney can make decisions in the person's best interests about buying/selling property, banking, benefits, pensions, rebates, income, inheritance, tax, mortgages, rent, household expenses, insurance, maintenance of property, investments, repaying loans, payment of medical or care fees, purchasing vehicles, equipment or any other help the person needs.
Court Appointed Deputy	Check whether the Deputy has been appointed to manage Property and Affairs or Personal Welfare and what remit/restrictions the Court has placed on their deputyship

Section 1: The decision to be made

The decision maker needs to clarify and document the decision to be made.

- If there is a possibility that the person will regain capacity it might be appropriate to defer the decision. These instances might include:
- The cause of the lack of capacity can be treated
- There is scope for the person to learn new skills or have new experiences which could increase their ability to make decisions
- The person's capacity fluctuates

Section 2: People consulted as part of the decision making process

It is a common misconception that it is only the person's family members that need to be consulted as part of the best interests process. In fact, the Code of Practice doesn't mention "family" in the best interests guidance at all. The people that the MCA asks the decision maker to include in the process are:

- Anyone engaged in caring for the person or interested in their welfare
- Anyone named by the person to be consulted

In the majority of cases this will include a family member but it could equally include a close friend or neighbour. Use the time you have to consult the most relevant people involved in the person's life and any professionals involved with the person.

If there is anyone that you have specifically chosen not to consult you should indicate this on the form and state why you made this decision. If there are safeguarding concerns you should follow your local procedures.

Section 3: IMCA instruction / representation

If the incapacitated person has no friends or family who it would be appropriate to consult as part of the decision making process, there are certain situations in which the Decision Maker must or may need to instruct an IMCA

Section 4: Options available in relation to the decision

In relation to these options it is best practice to indicate the advantages and disadvantages for each option. How restrictive the decision is will be a factor to consider and it will be important to decide which option (s) are the least restrictive as part of your decision making and the least restrictive option to achieve the support plan should be selected.

Stage 3: Consider whether the proposal amounts to a Deprivation

If the relevant person lacks the capacity to consent to be accommodated, the proposed plan is in the person's Best Interest and the proposed package of support is in a setting other than a hospital or care home, the following questions need to be considered:

To determine whether an individual has been deprived of their liberty, specific factors need to be considered such as the type, duration, effects and manner of implementation of the measures in question. The difference between deprivation of and restriction of liberty is one of degree or intensity; it is useful to envisage a scale which moves from 'restriction' or 'restraint' to 'deprivation of liberty'.

These questions may help establish whether an individual is deprived of their liberty in this context:

- To what extent is the person's ability to access the community limited by themselves and by others and in what circumstances?
- Within their place of residence, to what extent is the person
    - actively supervised
    - liable to be supervised
    - not liable to be supervised by others even when risks may arise?

- Is physical intervention used? If so, how often? What type? For how long? And what effect does it have on the person?
- Do others control their finances?
- How would the care regime respond to the corresponding risks if the person attempted to leave either to access the community or to simply not return?
- Are there regular private times, where the person has no direct carer supervision?
- Is their contact with the outside world restricted? If so, how often? How? For how long?
- And what effect does this have on the person?
- To what extent is the person able to decline assistance when it is available?

Providers should err on the side of caution when deciding what constitutes a Deprivation of Liberty and the above questions should be used as an 'Aide Memoire' only and is not substitute for professional judgement. Following completion and identification of a potential deprivation, submit this to the identified responsible commissioner to consider the need for an assessment.

Date Completed	Date of notification to CCG	Identified Person at CCG

Signed:	Date:
Position / Job role:	Location of assessment:

Partners in improving local health

North of England Commissioning Support

ACCESS TO LEGAL ADVICE FOR CLINICAL COMMISSIONING GROUPS

NECS Governance Team provides a service to facilitate access to legal advice for CCGs, some of which are signed up to the HealthTrust Europe Framework. However, depending on the nature and urgency of the advice required, the CCG officer with gatekeeper responsibility for legal affairs may agree that the requester may make direct contact with the legal adviser on the approved list for specific purposes.

This form should be completed and forwarded to the NECS Senior Governance Manager for action. An estimate will be obtained by the NECS Senior Governance Manager and shared with the CCG officer with gatekeeper responsibility for legal affairs for approval of the spend. Once costs are agreed, the NECS Senior Governance Manager will confirm this with the legal firm and pass on individual contact details of the requester to progress the legal advice.

Details of all requests for legal advice will be logged by the NECS Senior Governance Manager therefore in any circumstances where the CCG gatekeeper for legal affairs agrees that a direct contact may be made between the requester and a legal firm the NECS Senior Governance Manager will need to be informed of agreed costs so that these can be logged on the register.

Date or request		
Name of requester		
Job title		
Location / address		
Telephone / mobile		
E-mail address		
Name of CCG(s) for which advice is being sought		
Purpose for which legal advice will be required *(avoiding use of personal confidential data)*		
Brief issues to be addressed by legal firm and any particular requirements e.g. whether a face to face meeting is required.		
Timescale required for advice		

Authorised by - (CCG gatekeeper with responsibility for legal affairs) Name / job title	
Date authorised by CCG	
Preferred legal firm/ legal adviser (if any)	
Reason for selection of preferred legal firm (if any)	

Please return completed form to: NECS Senior Governance Manager, Riverside House, Goldcrest Way, Newburn Riverside Business Park, Newcastle upon Tyne, NE15 8NY or by scanning the form and emailing it to: necsu.legal@nhs.net,

Date request received by NECS Governance Team	
Estimated cost for approval by CCG	
Costs approved / declined by (CCG)	
Legal firm instructed (date)	
Purchase order number (to be advised to legal firm for quoting on invoice)	

Following approval a copy of this form will be passed to the requester and the law firm / legal adviser involved, confirming authority to proceed. A purchase order will be raised under the name of the CCG