Bath & North East Somerset
Community Safety & Safeguarding Partnership

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Mental Capacity Act 2005 Multi-Agency Policy Statement

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1 Introduction

1.1 This multi-agency policy statement sets out the high level aims and objectives of all health and social care providers across Bath and North East Somerset (B&NES) to implement the Mental Capacity Act 2005 (MCA).

1.2 The MCA came into force in 2007, and was later amended on the 1st April 2009 (by way of the Mental Health Act 2007) to include the Deprivation of Liberty Safeguards (DoLS).

1.3 The MCA was amended for a second time in May 2019 by way of the Mental Capacity (Amendment) Act 2019 which introduced the Liberty Protection Safeguards (LPS). LPS is the new process for authorising the care plans for persons who lack capacity to consent to them, when such arrangements amount to a deprivation of their liberty. LPS is to replace the current DoLS process and is currently due to be implemented in April 2022.

1.4 This statement will also address both DoLS and LPS

2 The Key Provisions of the MCA

2.1 The MCA can be summarised as providing a statutory framework to empower and protect vulnerable adults (16+) who may have difficulty making at least some decisions due to a lack of mental capacity **because** of an impairment of or disturbance in the functioning of the mind or brain.

2.2 The Act makes it clear who can take decisions, in which situations and how they should go about this. It also makes a number of provisions that enable adults to plan ahead for a time in the future when they may lack capacity. For example, the ability to make a Lasting Power of Attorney (LPA) for finance and/or health and welfare, and advance decisions to refuse treatment. These provisions are available to individuals who are 18 years and above.

2.3 In short, the MCA enshrines in statute, best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf.

2.4 The Act also introduced a new Court of Protection that can deal with welfare matters as well as financial ones and an Office of the Public Guardian to keep a register and monitor LPA's and Deputy's appointed by the Court to act on behalf of individuals who lack capacity.

2.5 The MCA applies in England and Wales to everyone who provides care, treatment or support to people aged 16 years or over who may lack capacity to make some decisions for themselves.

2.6 The Act provides a statutory definition of when a person lacks capacity and sets out a two stage test for determining this, but importantly, the Act's first principle states that capacity must be assumed unless there is clear evidence to establish otherwise.

2.7 The MCA also provides a checklist which **must** be applied when determining what is in the best interests of a person who lacks the capacity to make decisions for themselves. This includes a duty to consult with people who have an interest in the person's welfare (both professionals and family members).

2.8 The MCA provides a level of protection from liability for staff for the acts (including restraint) taken on behalf of an incapacitated person if it can be shown that the provisions of the Act have been followed.

2.9 The Act introduced a statutory advocacy service for people who lack capacity called the Independent Mental Capacity Advocate (IMCA) service. The IMCA service **must** be consulted in some circumstances and **may** be consulted in others.

2.10 It also introduced new **criminal** offences (under Section 44) of wilful neglect or ill treatment by individuals who care for a person who lacks capacity to consent to at least some elements of their care or treatment.

2.11 The Deprivation of Liberty Safeguards (DoLS - as an amendment to the MCA) were introduced to provide a legal process and suitable protection for people in **care homes and hospitals**, who lack capacity to consent to their care arrangements which deprive them of their liberty within the meaning of Article 5 of the European Convention on Human Rights.

2.12 The DoLS scheme provides the framework for authorising the deprivation of liberty if it is evidently in the person's best interests, and is a necessary and proportionate response to ensure that they receive care and treatment to maintain their health and wellbeing. The Safeguards also ensure that the person and their representative, have a legal right to challenge the Authorisation in the Court of Protection.

2.13 However, currently, if care arrangements amount to deprivation of liberty in a community setting, where the state is either involved in arranging the care provided, or are aware of it, the Local Authority or in some instances the Clinical Commissioning Group (soon to be known as Integrated Care Systems (ICS) from 1st April 2022) are

responsible for making an application to the Court of Protection to seek lawful authorisation for the care arrangements.

2.14 As noted above, the Liberty Protection Safeguards (LPS) are due to replace the DoLS scheme in April 2022 as the process for authorising care arrangements for people who lack capacity when such arrangements amount to a deprivation of liberty. LPS will cover **all** care settings, including people's own homes and supported living, and so will not just apply to care homes and hospitals as is currently the case with DoLS. It will introduce a new process, and requirements, for the collection of evidence upon which the responsible body will authorise an individual's deprivation of liberty.

2.15 A new combined LPS and MCA Code of Practice (plus regulations) are currently out for consultation – however the exact date of the publication of the 'final' version of these documents and the implementation of LPS is as yet unknown.

2.16 A phrase often used in the context of the MCA is that of **'executive functioning'** sometimes referred to as **'executive capacity'**. This refers to a person's ability to organise, plan and carry out decisions that they appear able to make for themselves. A mismatch between the person's ability to respond to questions in the abstract and their actions when faced with the same situations in reality can be suggestive of problems with their executive functioning. This can be common in cases of self-neglect where, for example, an individual appears to be able to understand the need to change clothes, wash and take medication but their subsequent actions demonstrate they don't follow such decisions through in practice. It often relates to people with an acquired brain injury. It is unlikely that a conclusion could be reached that somebody lacks executive functioning due to their mental disorder on the basis of a single assessment visit. There should normally be examples of a repeated mismatch between what an individual says and what they actually do in order for this conclusion to be reached. Failure to complete a sufficiently robust capacity assessment in such circumstances can potentially leave that individual at significant risk. It is important to note that practitioners who have doubts about a person's executive functioning must still relate this to the functional and diagnostic tests of capacity outlined in the MCA. There is not a separate or different capacity assessment for executive functioning. If there is a repeated mismatch between the words and actions which leaves an individual at risk then this is most likely to demonstrate an inability to use/weigh up relevant information. However, as always, evidence must be provided for an individual lacking capacity on this basis and a distinction should be made between an individual lacking capacity and one making an unwise decision.

3 Legal and Policy Context

3.1 This policy statement sits within a wider legal and policy framework as follows:

- The Mental Capacity Act 2005
- The Mental Capacity (Amendment) Act 2019
- The Mental Capacity Act Code of Practice (DH 2007)
- The Deprivation of Liberty Safeguards Code of Practice (DH 2008)
- The Care Act 2014
- B&NES Safeguarding Adults Policy and Procedures
- The Data Protection Act 1998
- The Equality Act 2010
- The Human Rights Act 1998
- The Mental Health Act 1983 (as amended 2007)
- The Health and Social Care Act 2008

4 Policy Statement

4.1 Health and social care providers across B&NES are committed to ensuring that people who use their services, and who lack capacity to make decisions, are provided with high quality care from a trained and competent workforce that appropriately applies the MCA in day to day practice.

4.2 The importance of the MCA must be recognised by all providers in B&NES as fundamental to support human rights around autonomy, choice and control for adults who experience difficulty with decision making with regard to their health and care needs.

4.3 All B&NES health and social care providers will apply the MCA Code of Practice but will also will have their own agency specific policies, procedures and/or guidance to fully implement this policy statement and deliver on the stated outcomes.

4.4 Furthermore, those practitioners who are involved in more formal assessments of capacity (covering significant decisions), and making best interests decisions on behalf of service users, have a duty to evidence their application of the MCA Code in accordance with local recording frameworks.

4.5 B&NES health and social care providers will apply the DoLS Code of Practice and agency specific procedures and guidance to ensure compliance with the legislation.

4.6 All DoLS assessments and reviews will be carried out by appropriately trained and competent assessors and within the legally prescribed timescales wherever possible.

4.7 B&NES Council in its role as DoLS Supervisory Body, will ensure that it has appropriate procedures, processes and staff in place to maintain the most effective delivery possible of the DoLS service. This delivery of the service continues to occur in the context of the Cheshire West Supreme Court Judgment handed down on the 19 March 2014 which resulted in a 10 fold increase in DoLS referrals across the country. This was due to its lowering of the threshold for when care arrangements amount to a deprivation of liberty.

4.8 Until LPS is implemented, B&NES Council and BaNES Clinical Commissioning Group will take the necessary steps to make Court of Protection applications for anyone being deprived of their liberty in a domestic setting who fulfils the necessary criteria.

4.9 Each agency will take responsibility for ensuring that service users and carers are aware of their rights under the MCA through the reproduction of existing material or the distribution of agency specific material via print, web or other methods based on individual needs.

4.10 It is recognised that effective implementation of the MCA is dependent on a skilled and knowledgeable workforce therefore all providers in B&NES are committed to ensuring that:

- Role and grade appropriate MCA training will be provided to all new staff as part of their induction
- Appropriate staff (those tasked with making more significant decisions on behalf of service users) will receive more in depth training as soon as possible thereafter
- MCA refresher/update training will be provided periodically as determined by each agency
- MCA/DoLS refresher/update will be provided to all Best Interest Assessors (BIAs) on an annual basis
- MCA compliant practice will develop in line with emerging case law and guidance
- The MCA will feature regularly in staff supervision sessions and team meetings to ensure quality and consistency of practice
- Agencies will conduct self-determined regular MCA audit exercises as a way of measuring progress, identifying gaps and planning for improvement
- Agencies will ensure all staff are aware of and trained appropriately for the implementation of LPS. This will include the conversion of existing Best Interest Assessors (BIAs) to Approved Mental

Capacity Professionals (AMCPs) to ensure they can fulfil their statutory duties under LPS once implemented

- Records will be kept to evidence all of the above

5 Guiding Principles

5.1 This policy statement fully adopts the 5 statutory principles of the MCA. It is acknowledged that if these principles are followed, this should provide protection for the human rights of the incapacitated person and support professionals to implement the Act appropriately.

a) **A presumption of capacity** – every person 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.

b) **Individuals being supported to make their own decisions** – a person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

c) **Unwise decisions** - a person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

d) **Best interests** - an act done or decision made, under this Act for, or on behalf of, a person who lacks capacity must be done, or made, in his/her best interests.

e) **Least restrictive option** – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms

6 Scope

6.1 This policy statement applies to:

- All social care service users or patients in B&NES who are over the age of 16 years and may lack capacity in relation to decisions or actions relating to the provision of their health and/or social care services

- All social care service users or patients in B&NES who are over the age of 18 years and subject to a DoLS referral, assessment, authorisation or review process

- All social care service users or health patients in B&NES who are over the age of 16 years and subject to a LPS referral, assessment, authorisation or review process when it is implemented in April 2022

- All practitioners and managers employed by B&NES health and/or social care agencies who are working with service users/patients who may lack mental capacity to make decisions or give consent to any aspect of their care or treatment

- Those practitioners who place/admit service users and patients to care homes or hospitals which may bring them within the scope of the DoLS – or LPS when implemented in April 2022

- Best Interests Assessors and Mental Health Assessors who undertake DoLS (and in future, LPS) assessments for people ordinarily resident in B&NES

6.1 This policy statement applies equally across all staff and client groups regardless of age (for those 16 years or over), race, disability, gender, religion or belief, sexual orientation or gender reassignment, pregnancy and maternity and marriage/civil partnership status.

7 Policy Outcomes

7.1 The outcomes this policy statement aims to achieve are:

For the wider provisions of the MCA:

- All appropriate health and social care staff in B&NES are aware of their legal duty to apply the MCA in line with the Codes of Practice and developing case law

- All patients and service users in B&NES are aware that the services they receive will be fully MCA compliant as necessary

For the Deprivation of Liberty Safeguards (until replaced by LPS):

- Both the Local Authority and care homes and hospitals in B&NES deliver on their commitment to apply the Deprivation of Liberty Safeguards in line with the DoLS Code of Practice and developing case law

- Staff in other settings, where deprivation of liberty may be occurring e.g. supported living, shared lives, are aware of their responsibility to raise their concerns with the commissioner of the care

- B&NES Council and BaNES CCG make necessary arrangements to make Court of Protection applications, in line with guidance from the Court, for anyone deprived of their liberty in a domestic setting

- Those professionals in B&NES who admit people to care are aware of the DoLS requirements and what it means when someone is subject to a DoLS Authorisation

For the Liberty Protection Safeguards (once implemented):

- For staff in all health and social care teams and settings to be aware of, and appropriately trained in, LPS ahead of its implementation date

- For staff in all health and social care teams and settings to deliver on a commitment to apply LPS when implemented, in line with the statute, published Code of Practice, regulations and emerging case law

8 Monitoring, Review and Evaluation

8.1 This multi-agency policy statement will be reviewed every three years by the B&NES MCA Quality and Practice Group, but may be reviewed sooner if this is warranted by a change in law or national policy.

8.2 The implementation of this multi-agency policy statement will be routinely monitored to ensure that agencies comply with it, and evaluated to determine whether the stated outcomes are being realised.

9 Further Reading & References

9.1 Mental Capacity Act (2005) Code of Practice
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

Deprivation of Liberty Safeguards – Code of Practice to supplement the main MCA 2005 Code of Practice
https://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf

Gov.uk guidance on LPS and LPS fact sheets
https://www.gov.uk/government/collections/mental-capacity-amendment-act-2019-liberty-protection-safeguards-lps