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Policy Statement

For most people, making their own decisions and choices, is a matter of some considerable importance. It is how we express our identities, and exercise our personal freedoms. Making our own choices – where we live, what we do, who we see – is a basic human right which is fundamental to our sense of self and our quality of life. However, a number of barriers can prevent people from actively taking part in decisions which affect their lives. Where a person’s ability to make such informed decisions is in question, there is a fine balance to be reached between protecting their rights and autonomy, and ensuring that appropriate action is taken in their best interests.

The Mental Capacity Act (MCA) 2005 and associated statutory guidance provides a statutory and quality framework to empower and protect some of the most vulnerable people in our society: those who due to a mental disorder – whether temporary or permanent - have difficulty in making their own informed decisions. The MCA is the legal framework which builds upon and enshrines in statute principles which previously existed within common law concerning people who may lack mental capacity to make decisions, and those who need to take decisions on their behalf.

The Mental Capacity Act Deprivation of Liberty Safeguards (the DoLS) provide a legal framework for the lawful deprivation of liberty of those people who lack capacity to consent to arrangements made for their care or treatment in either a hospital or care home, when it is proportionate and necessary for them to be deprived of their liberty in their own best interests to protect them from harm.

The issue of whether a person aged 16 years of age or over has the mental capacity to make a decision commonly arises in health and social care settings, but may also arise in other service areas. All professional groups have the potential to be in situations where they are required to assess the mental capacity of an individual to make a particular decision and to make best interests decisions. It is critical therefore, that all professional groups are aware of and comply with the MCA 2005.

Professionals often have a key role in helping and supporting people to understand what decisions need to be made and why, and what the consequences of those decisions are. This guidance is intended to increase awareness of the options available to people who may lack capacity now, or in the future.

Gateshead’s Safeguarding Adults Board’s vision is to ensure good practice and a coherent approach in concordance with all provisions of the MCA, so that organisations work together to safeguard autonomy, empower and engage, and promote and protect the rights and liberties of Gateshead’s most vulnerable citizens.
Glossary and Acronyms

(The) Act - the Mental Capacity Act 2005

ABI (Acquired brain injury) - brain damage caused by events after birth, which can result in cognitive, physical, emotional, or behavioural impairments leading to permanent or temporary changes in functioning. ABIs result from either traumatic brain injury (accidents, assaults, neurosurgery, and head injury) or non traumatic injury (stroke, brain tumours, infection, poisoning, hypoxia, ischemia, encephalopathy or substance abuse).

ADRT (Advance decision to refuse treatment) - a decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision. It has the same effect as a contemporaneous refusal of the specified medical treatment.

Adult at risk – replaces the term “vulnerable adult” and means a person over 18 who is in receipt of or eligible for community care services.

AMHP (Approved Mental Health Professional) - a Social Worker, Nurse, Occupational Therapist or Psychologist with more than 2 years post qualifying experience who has undertaken specialist training to be able to coordinate and carry out statutory assessments and make applications to detain people under the Mental Health Act 1983 (MHA83).

Attorney - a person who has been appointed under either a Lasting Power of Attorney or (prior to October 2007) an Enduring Power of Attorney. An attorney has the legal right to make decisions on behalf of the donor, providing these decisions are within the scope of their authority and the Power has been registered with the Office of the Public Guardian. There are now personal welfare and financial Lasting Powers of Attorney.

Best Interests - any act done or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the MCA 2005 sets out a non-exhaustive, best interests checklist.

BIA (Best Interests Assessor) - a Social Worker, Nurse, Occupational Therapist or Psychologist with more than 2 years post qualifying experience who has under taken specialist training to be able to carry out statutory assessments under the Deprivation of Liberty Safeguards (DoLS).

Capacity - the ability to make an informed decision about a specific matter at the time it needs to be made and understanding the likely consequences of that decision.

Carer - a person (for example a relative, friend or neighbour) who looks after someone in an unpaid capacity, who through illness or disability is unable to look after her/himself. A carer may be an adult, child or young person.

CCG (Clinical Commissioning Group) - CCGs are clinically led groups that include all of the GP groups in their geographical area. They manage primary care commissioning, including holding the NHS Contracts for GP practices NHS. CCGs are overseen by NHS England. Gateshead Clinical Commissioning Group represents 34 GP practices in Gateshead and covers a population of around 205,000.

Children - within the MCA this refers to people who are below the age of 16 years. This is different from the definition within the Children Act 1989 and the law more generally where the term child is used to refer to people aged less than 18 years of age.

Conflict of interest - occurs when an individual or organisation is involved in multiple interests, one of which could possibly corrupt the motivation for an act in the other.

Consent - the voluntary and continuing permission of the capacitous person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. No one can consent on behalf of another adult.
**Court of Protection** - a superior court of record which is able to establish legal precedent. It deals with decision making for those over 16 years of age who may lack capacity to make specific decisions for themselves, usually concerning property and affairs, healthcare and personal welfare.

**CPA (Care Programme Approach)** - the operating framework of mental health services, introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11, ‘The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services’, published by the Department of Health in 1990. CPA requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

**CPS (Crown Prosecution Service)** - the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

**CQC (Care Quality Commission)** - a non-departmental public body of the UK government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people’s own homes.

**Decision maker** - the person who is responsible for deciding what is in the Best Interests of a person who lacks capacity. Who this is, is dependant on the decision that needs to be made. For example, the decision maker may be the carer responsible for the day to day care, the medic proposing to give or withhold treatment, the social worker responsible for care arrangements etc.

**Dementia** - a group of related symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding, judgment. Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases with age, and the condition usually occurs in people over the age of 65.

**Deputy** - a person appointed by the Court of Protection with ongoing legal authority to make particular decisions on behalf of the person who lacks capacity. Deputies for personal welfare (including healthcare) decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court’s authority or there is no other way of settling the matter in the Best Interests of the person who lacks capacity to make particular welfare decisions.

**DoL (Deprivation of Liberty)** - the term used in the European Convention on Human Rights about circumstances when a person’s freedom is taken away. There is no simple definition of deprivation of liberty, but case law is defining its meaning in practice.

**DoLS (Deprivation of Liberty Safeguards)** - a specific legal process within the Mental Capacity Act to protect people in care homes or hospitals who may lack capacity and are being varied for in an extremely restrictive manner.

**Donor** - a capacitous person who makes a Lasting Power of Attorney (LPA) to appoint a person (or persons) to manage their assets or to make personal welfare decisions at a time in the future when they may lack capacity.

**Duty of care** - the responsibility or the legal obligation of a person or organisation to adhere to a standard of reasonable care and avoid acts or omissions likely to cause harm to others.

**EPA (Enduring Power of Attorney)** - created under the Enduring Powers of Attorney Act 1985 to deal with property and financial affairs. Existing EPAs made before October 2007 continue to be valid.

**Independent Advocacy** - action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice. All advocacy projects within Gateshead are signed up to a code of practice which describes the different types of advocacy and the principles to be followed.

**IMCA Service (Independent Mental Capacity Advocacy)** - established by the Mental Capacity Act 2005 as a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. IMCAs make sure that major decisions for a person who lacks capacity are made in accordance with the MCA. IMCAs have statutory powers to access health and social care records.
**Intermediary** - someone appointed by the courts to help a vulnerable witness give their evidence either in a police interview or in court.

**Learning disability** - a group of disorders, present from birth, which are manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to Central Nervous System Dysfunction.

**Legal authority** – the statute which gives permission to act. In order to take action for or on behalf of someone who does not have capacity to consent, a legal authority must be established. This may come from the Mental Capacity Act, the Mental Health Act or the courts.

**LPA (Lasting Power of Attorney)** - enables a person initially with capacity to appoint another person to act on their behalf in relation to decisions about the donor’s financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used.

**Managing Authority** - the person or body with management responsibility for the hospital or care home in which a person is, or may become deprived of their liberty.

**MCA (Mental Capacity Act)** - the Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

**MCA Coordinator** - the member of the Safeguarding Adults Coordination team responsible for ensuring the quality and efficacy of the services provided to adults who may lack capacity within Gateshead. The MCA Coordinator supervises the council’s BIA’s, oversees the IMCA contract, provides practice advice and guidance to council staff, commissioned providers, service users and carers, delivers training and awareness raising and oversees the DoLS process.

**MCA Lead/ Champion** - this may be a Team Manager, Senior Practitioner, BIA Sister, Matron or Team member who acts as an identified source of expertise on the MCA within their specific agency.

**MCA Working Group** - a sub group of the Safeguarding Adults Board which works together to develop Mental Capacity Act and Deprivation of Liberty Safeguards practice and strengthen partnership arrangements across Gateshead.

**Mediation** - a voluntary, facilitative process that assists parties to reach a mutually acceptable outcome. Mediation is a non-adversarial and voluntary process. A mediator is independent and acts as a facilitator. A mediator works with the parties to identify their concerns and helps them to resolve areas of disagreement. Parties who take part in mediation have a real stake in the process and a mediator empowers them to resolve the dispute themselves.

**Mental Capacity** - a person’s ability to make a specific decision at a specific time. A legal definition is contained in Section 2 of the Mental Capacity Act 2005.

**Mental Disorder** – as defined by Section 1 of the Mental Health Act 1983, “any disorder or disability of the mind”.

**Mental illness** - a health condition that changes a person’s thinking, feelings, or behaviour (or all three), and causes the person distress and difficulty in functioning. Mental illness is severe in some cases and mild in others. There are many different mental illnesses, including depression, schizophrenia, attention deficit hyperactivity disorder (ADHD), autism, and obsessive-compulsive disorder. Each illness alters a person’s thoughts, feelings, and/or behaviours in distinct ways.

**Mental Health Assessor** – a doctor who has undergone specialist training in order to be able to undertake specific statutory assessments under the DoLS.

**MHA83 (Mental Health Act 1983)** - the legislation which sets out the framework for the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes, unofficially known as “sectioning”. Its use is reviewed and regulated by the Care Quality Commission.

**OPG (Office of the Public Guardian)** - established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.
Proportionality - a proportionate and least restrictive response to the risk presented.

Public interest - a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Restraint - the use or threat of force to undertake an act which the person resists, or the restriction of the person’s liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

RPR (Relevant Person’s Representative) - a person (usually a family member or friend) appointed to support someone who is subject to authorisation under the DoLS. RPRs have the right to request that a DoLS authorisation is reviewed, or to appeal against it. If there is no one suitable to undertake this role, the Supervisory Body will appoint an IMCA as a paid RPR.

Safeguarding Adults - is used to describe all work to help Adults at Risk stay safe from significant harm. It replaces the term POVA (Protection of Vulnerable Adults).

Safeguarding Adults Co-ordination Team - the team within Gateshead Council which provides strategic overview of all safeguarding and MCA and DoLS issues, and also provides operational support, guidance and advice to professionals and the Safeguarding Adults Board.

SAB (Safeguarding Adults Board) - is the partnership of statutory and non statutory organisations that provides strategic leadership for Safeguarding Adults in Gateshead. The SAB has governance oversight of MCA and DoLS activity within Gateshead and is supported by a range of subgroups including the MCA Working Group.

Standard Authorisation - the formal agreement to deprive a relevant person of their liberty in the relevant hospital or care home, given by the Supervisory Body, after completion of the statutory assessment process.

Statement of wishes and feelings - a person with capacity may express their wishes and feelings about their future medical treatment, where they would choose to live, how they would wish to be cared for, in the event they lose capacity in the future. These are non-binding but should be used by relevant professionals for consideration when making Best Interests decisions for a person who lacks capacity.

Supervisory Body - the local authority that is responsible for receiving deprivation of liberty requests, commissioning the assessments and, where all the assessments agree, authorising deprivation of liberty.

Urgent Authorisation - an authorisation given by a Managing Authority under the DoLS for a maximum of seven days, which may be extended by a maximum of a further seven days by a Supervisory Body, that gives the Managing Authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

Vulnerable adult - this term has been replaced by “adult at risk”, see above.

Wilful neglect - an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. Wilful neglect is identified as an offence under Section 44 of the Mental Capacity Act 2005 and applies to anyone caring for a person who lacks capacity, including family carers, healthcare and social care staff in care homes or hospitals and those who provide care in a person’s home.

Young Person - within the MCA this refers to people aged 16-17 years to whom most of the Act applies.
Introduction

Purpose
Professionals need to be able to determine a person’s mental capacity in relation to the decisions they face both throughout the adult care process and more widely in their lives. The MCA imposes strict obligations upon staff when assessing capacity and when reaching decisions as to the best interests of incapacitated persons. It also provides legal protection to staff who fulfil these obligations and who follow the statutory procedures carefully and reasonably.

The purpose of this framework, therefore, is to assist staff working within Gateshead to understand their responsibilities under the MCA and to access guidance to assist them in fulfilling them.

The Codes of Practice
Nothing within this document is intended to replace or conflict with the guidance given within the Mental Capacity Act Code of Practice or the Deprivation of Liberty Safeguards Code of Practice. The codes are excellent documents, which should be the first point of reference for those working under the MCA.

Certain categories of people are legally required to ‘have regard to’ relevant guidance in the Code of Practice. This means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and they should be able to explain how they have had regard to the Code when acting or making decisions.

The categories of people that are required to have regard to the Code of Practice include anyone who is:

- **carrying out research** approved in accordance with the Act
- **acting in a professional capacity** for, or in relation to, a person who lacks capacity working
- **being paid for acts** for or in relation to a person who lacks capacity.

The last two categories cover a wide range of people. People acting in a professional capacity may include:

- a variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc)
- social care staff (social workers, care managers, etc)
- others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as **ambulance crew, housing workers, or police officers**.

People who are being paid for acts for or in relation to a person who lacks capacity may include:

- **care assistants** in a care home
- **care workers** providing domiciliary care services, and
- **others who have been contracted** to provide a service to people who lack capacity to consent to that service.

However, the Act applies more generally to everyone who looks after, or cares for, someone who lacks capacity to make particular decisions for themselves. This includes family carers or other informal carers. Although these carers are not legally required to have regard to the Code of Practice, the guidance given in the Code will help them to understand the Act and apply it. They should follow the guidance in the Code as far as they are aware of it.
Scope

The MCA generally applies to people aged 16 years and over with the exception of children aged less than 16 years who lack capacity and will continue to lack capacity in relation to their property and financial affairs when they reach 18 years of age. Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 18 years.

It is therefore important that this framework is considered not just by adult services, but also by services working with children and young people.

The Deprivation of Liberty Safeguards (DoLS) only apply to those over 18 years of age.

Limitations of the Act

Sections 27-29 and section 62 of the MCA set out the specific decisions which can never be made or actions which can never be carried out under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection.

Nothing in the act permits a decision to be made on someone else’s behalf on any of the following matters:

- Consenting to marriage or a civil partnership.
- Consenting to have sexual relations.
- Consenting to a decree of divorce on the basis of two years’ separation.
- Consenting to the dissolution of a civil partnership.
- Consenting to a child being placed for adoption or making of an adoption order.
- Discharging parental responsibility for a child in matters not relating to child’s property.
- Giving consent under the Human Fertilisation and Embryology Act 1990

Where a person who lacks capacity to consent is currently detained and being treated under Part 4 of the Mental Health Act 1983, nothing in the Mental Capacity Act authorises anyone to:

- Give the person treatment for mental disorder, or
- Consent to the person being given treatment for mental disorder.

Nothing in the act permits a decision on voting, at an election for any public office or at a referendum.
to be made on behalf of a person who lacks capacity to vote.

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

Further guidance on the limitations of the Act can be found in Chapter 1 of the MCA Code of Practice.

**Working in partnership**

This framework has been collaboratively created by representatives of Gateshead Safeguarding Adults Board’s MCA Working group, in order to describe working arrangements and provide guidance and consistency to those working with Gateshead citizens who may lack capacity.

The framework is closely related to, and intended to be read alongside of, the Gateshead Safeguarding Adults from Abuse Multi-Agency Policy and procedures.

It is recognised that partner agencies will have, or may need to develop their own specific MCA policies, procedures and guidance to meet the needs of their particular context and function. This policy should therefore be read in conjunction with any agency-specific policies and procedures.

**Structure of the document**

This document is separated into 4 main parts:

1. **Policy** – this section outlines the policy structures which underpin MCA practice in Gateshead, including a detailed glossary of terms, the legal context, exploration of the role of the CQC and a discussion of how clear MCA leadership can be structured within individual agencies.

2. **Considerations for particular agencies** – this section examines the impact of the MCA on specific agencies within Gateshead and considers some of the challenges presented.

3. **MCA practice and procedural guidance** – this section considers specific elements and functions of the MCA, and offers practice and procedural guidance.

4. **DoLS procedural guidance** – this section sets out Gateshead’s procedure for the effective operation of the Deprivation of Liberty Safeguards.

**Review**

The interpretation and operation of the MCA will frequently change following developments in case law, and the evolution of practice. It is therefore intended that this framework be a living document, which will be refreshed, reviewed, updated and added to on a regular basis by the members of the MCA Working Group.
Section 1 - Policy

1.1 Principles and Values

The guiding principles, as set out in Section 1 of MCA, must underpin all practice with those who may lack capacity.

The Guiding Principles
Mental Capacity Act 2005,
Section 1

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

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

3 A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4 An act done or decision made, under this Act for on behalf of a person who lacks capacity must be done or made in his best interests.

5 Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom.

Staff must work on the presumption that adults have mental capacity to make informed choices about how they live their lives. All interventions need to take into account the ability of adults to make their own informed choices about the way they want to live and the risks they want to take.

Issues of mental capacity and the ability to give informed consent should be considered as central to assessment, treatment and care planning arrangements. Care needs to be taken to explain things properly and thoroughly, in a way that the person can best understand using clear language and whatever communication aids that are appropriate for the individual. People must not be unnecessarily rushed into making decisions and wherever possible should be afforded time to think things through or talk them over with someone they trust.

Where there is a suggestion that a person may lack capacity to make a specific decision at the time it needs to be made, a formal assessment of capacity must be undertaken to determine this. Remember, a person’s capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour.

Mental capacity is time and decision specific: this means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

The MCA should never be used to enforce one person’s will onto another: if a person can understand, retain and consider the options before them, to make an informed choice, they are entitled to make it, regardless of the concerns or preferences of others. A person making a decision that others believe unwise does not necessarily lack capacity.

If a person is found to lack capacity to make a decision themselves, steps must be taken to determine what action (if any) is proportionate and in the best interests of that person. A best interests decision should never be made purely on the basis of professional advice or opinion: consultation must take place to consider the person’s context of values, beliefs and culture, and the likely impact of different decisions on the person’s quality of life and relationships.

All life involves risk, and the best interests process must not seek to eliminate risk, or make a person so safe that they are miserable or unnecessarily restricted. Staff have a duty of care not only in respect of a person’s physical health and safety, but also their human rights of privacy, dignity, individuality and freedom of choice.
1.2 The Legal Context

The MCA received Royal assent on 7th April 2005 and came into force in two phases: April and October 2007. It replaced Part 7 of the Mental Health Act 1983 and the whole of the Enduring Power of Attorney Act 1985. It introduced a new Court of Protection with more comprehensive powers.

The Deprivation of Liberty Safeguards (the DoLS) were added into the MCA in 2007, to provide safeguards for people who lack capacity to consent to treatment or care in hospitals or care homes in circumstances that amount to depriving them of their liberty. The DoLS came into force in 2009.

Section 44 of the Act introduced two new criminal offences – *ill treatment or wilful neglect of a person who lacks capacity*. A person found guilty of such an offence may be liable to imprisonment. The safeguarding adults process will always run alongside any criminal proceedings under Section 44.

The MCA applies in conjunction with other legislation relevant to people who may lack capacity, including, but are not limited to:-

- **The National Assistance Act 1948**
- **The Mental Health Act 1983**
- **The Police and Criminal Evidence Act 1984**
- **The National Health Service and Community Care Act 1990**
- **The Disability Discrimination Act 1995**
- **The Human Rights Act 1998**
- **The Data Protection Act 1998**
- **The Care Standards Act 2000**
- **The Human Tissue Act 2004**
- **The NHS Redress Act 2006**
- **The Mental Health Act 2007**
- **The Health and Social Care Act 2008**
- **The Equality Act 2010**

To access any of the documents above visit www.legislation.gov.uk

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**The Care Bill 2013**
http://services.parliament.uk/bills/

Some of the most relevant statutory documents, supporting codes and government guidance are:-

**No Secrets 2000**

**The MCA Code of Practice**

**The DoLS Code of Practice**
http://webarchive.nationalarchives.gov.uk/

**The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009**
http://www.legislation.gov.uk/uksi

**The Mental Health Act Code of Practice**
http://www.dh.gov.uk

**Social Care Act 2008 (Registration Requirements) regulations 2009**
http://www.legislation.gov.uk/uksi
1.3 The role of the Care Quality Commission (CQC)

The CQC takes inclusion and human rights very seriously, and has made “ Strengthening how we deliver our responsibilities in terms of mental health and mental capacity” one of its 6 priorities for the next 3 years. The document “Raising standards, putting people first – our strategy for 2013 to 2016”, can be downloaded from:

http://www.cqc.org.uk/public/

The CQC states,

“We recognise that when people’s ability to agree to and make decisions about their care and treatment is affected by ill health or mental disability, it is an issue for all health and adult social care services, not just mental health services... We will increase the level of training and guidance on mental capacity that we give to our frontline staff to strengthen the links between our assessment of providers’ practice under the Mental Capacity Act and their performance against the Health and Social Care Act regulations.”

The 2009 CQC document “Essential Standards of Quality and Safety”, states that all people who use services should be protected from abuse, or the risk of abuse and their human rights should be respected and upheld.

The CQC can set compliance actions and improvement actions, or take enforcement action under the Health and Social Care Act 2008 as a result of breaches of the Mental Capacity Act. The provisions of the MCA 2005 can be “relevant requirements” for enforcement purposes. For example:

- If people are not being involved in decisions about their care, the CQC can take action in relation to failure to comply with regulation 17 (outcome 1) of the essential standards of quality and safety.

- If people are not being properly supported to consent to the care, treatment and support they receive, the CQC can take action in relation failure to comply with regulation 18 (outcome 2) of the essential standards.

- If assessments of capacity and decision-making are not being undertaken in a way that complies with the codes of practice, the CQC can consider whether regulation 9 (outcome 4) of the essential standards is being met.

- If there are concerns about the use of restraint and people’s capacity to consent, the CQC can consider whether regulation 11 (outcome 7) of the essential standards is being met.

- CQC can also serve a warning notice about failure to comply with the Mental Capacity Act 2005, which is a ‘relevant enactment’ for Health and Social Care Act purposes.

The CQC was established as monitor of operation of the DoLS in England by the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009.
Under regulation 2, CQC must monitor the operation of DoLS and under regulation 3; report on the operation of DoLS to the Secretary of Health. To this end, the CQC produces an annual report which can be downloaded from: http://www.cqc.org.uk/public/reports-surveys-and-reviews/reports/deprivation-liberty-safeguards-2011/12.

In undertaking its role as monitor of the DoLS, the CQC:

1. Looks at documents and records of applications and authorisations under the DoLS including:
   - Completed forms
   - Notices
   - Any conditions imposed
   - Any requests for review
   - Plans of care, treatment and support
   - Other relevant documents.

2. Checks that the provider has recorded the steps taken to involve and inform the person, their family, friends and supporters.

3. Involves Relevant Person’s Representatives (RPRs), Independent Mental Capacity Advocates (IMCAs), Lasting Power of Attorneys (LPAs) or court deputies in survey samples.

4. Checks that the managing authority is keeping regular contact with the RPR.

5. Checks that records show that it has been explained to the relevant person that they can appeal to the Court of Protection.

6. Checks that the two-stage test of capacity has been undertaken and recorded.

7. Checks that assessments and care planning records are consistent with the Act’s code of practice guidelines.

Within “Raising standards, putting people first – our strategy for 2013 to 2016”, the CQC commits to,

“Continue to work with national organisations to better understand and fulfil our monitoring role under DoLS as case law and policy on deprivation of liberty are developed… develop our ability to monitor the activity of local social-services authorities in their role as ‘supervisory organisations’ in the Deprivation of Liberty Safeguards system… increase our understanding of people’s and their families’ experience of DoLS by listening more to community and advocacy organisations.”

The CQC has produced guidance for providers both in relation to the MCA and the DoLS. This is available to download from:

It is the responsibility of any professional who becomes aware of non compliance with, or breach of the MCA or the DoLS, to bring this to the attention of the CQC as soon as possible. Particular responsibility lies with those who are likely to be in a position to identify these issues, such as health and social care staff in direct practice, the Safeguarding Adults Coordination Team and local authority or NHS commissioners, who may detect issues through contract compliance monitoring.

In all cases, as well as informing the CQC, consideration should also be given as to whether a safeguarding adult’s alert should be made.

1.4 The MCA subgroup

Gateshead Safeguarding Adults Board has governance oversight for MCA compliance and activity within Gateshead. Priority four of the Safeguarding Adults Partnership Plan 2013/14 is to “Raise the strategic and operational profile of the Mental Capacity Act and the Deprivation of Liberty Safeguards.” In order to assist the board to achieve this, the MCA Working Group has been established, with representation from key agencies across the partnership. The Working Group has developed an Action Plan with five objectives:

- Raising awareness
- Policy and procedures
- Quality assurance
- IMCA
- Prevention

The members of the MCA Working Group work in partnership to implement this programme of work and drive Mental Capacity Act compliance and practice development.

1.5 Providing clear leadership within individual agencies

Agencies should commit to training both frontline and managerial staff in the functions of the MCA which are relevant to their particular area of focus. Such training needs to form part of the induction programme of new staff, and be repeated on regular basis for existing staff, as MCA practice is quickly evolving in response to judgements form the Court of Protection and the European Court of Human Rights.

Many agencies have robust training systems of their own in place. For those who do not, multi agency MCA and DoLS training is provided by Gateshead Council’s Safeguarding Adults Coordination Team. A number of excellent e-learning resources are also available from SCIE and can be accessed at:


All agencies represented in Gateshead’s Safeguarding Adults Partnership should identify a named, organisational MCA lead or champion, who will be responsible for ensuring the quality and efficacy of services provided to adults who may lack capacity.

The organisational MCA lead should act as a point of contact within their organisation, providing advice and guidance around issues relating to mental capacity. Organisational leads should seek to establish relationships across agencies so that a pool of knowledge is created. Organisational leads should, when possible, have membership of the MCA Working Group and attend the bi-monthly North East Regional MCA Local Implementation Network (LIN) to share knowledge and practice developments with peers.

As well as an identified organisational MCA lead, each organisation should ensure that appropriate arrangements are in place to swiftly access formal legal advice should the need arise. The local authority and all NHS bodies must be mindful of their obligations to make application to the Court of Protection, and have processes in place to do so where there is dispute or lack of clarity about what is in an incapacitated person’s best interests.

The MCA has implications for all aspects of work with adults who may lack capacity, and for all policies. Agencies should ensure that all policies and procedures are congruent and compliant with the MCA.

Any issues regarding the implementation and practice of the MCA should be brought to the attention of the organisational MCA Lead as and when they arise. These issues should be escalated internally as needed and fed into the MCA Working Group, which is a sub group of Gateshead Safeguarding Adults Board.

All those working within Gateshead have a duty and commitment to protect Adults at Risk. An allegation of abuse or neglect of an Adult at Risk who does not have capacity to consent on issues about their own safety will always give rise to action under the Safeguarding Adults process. Section 44 of the Act makes it a specific criminal offence to wilfully ill treat or neglect a person who lacks capacity.
Section 2 - Considerations for specific agencies

2.1 Gateshead Council

The Council has established strong systems working practices and training programmes around MCA and DoLS, to prioritise and invest in this area. The Council recognises that social care increasingly involves more complex clients, a great number of whom may lack capacity to make important decisions around residence, relationships, keeping themselves safe, personalisation and self directed care.

The confidence of the council’s front line social care workforce needs to be increased through learning and practice opportunities and effective clinical supervision which focus on:-

- working effectively and equally with clients and carers
- supporting autonomy and self determination.
- avoiding paternalism and risk averse practice.
- creative care planning and least restrictive practice.
- understanding how to assess capacity and make best interests decisions – not just in theory, but in practice.
- balancing risks against quality of life
- evidencing decision making and being open to challenge – from family members, IMCAs and other professionals.
- identifying the correct legal authority for taking action
- reflective practice

Managers and senior practitioners need to be confident in their skills and understanding, in order to identify when situations are becoming more complex and guide staff appropriately.

It is important that the provisions of the MCA are seen not just as the domain of social care teams, but as council wide priorities:

“The culture change in relation to working with people who lack capacity needs to continue. There are two particular challenges to address now. First, local authorities need policies to be developed not simply ‘on the MCA’ but on all aspects of the local authority’s activities – housing, transport, complaints, consultations, partnership working, personalisation, carers breaks and so on – as they relate to people with dementia, learning disabilities or brain injuries. It is now time to look at capacity issues more widely in relation to local authority activity.”

Lucy Bonnerjea, MCA Policy Lead, Department of Health 2012

2.2 NHS bodies

The term NHS bodies has enormously broad application. It is used here as a collective description of the numerous different services throughout Gateshead, operated and commissioned by NHS trusts and Gateshead CCG. These services address a vast range of needs such as general practice, dentistry, podiatry, physical illness (both acute and chronic), emergency treatment, rehabilitation, sexual health, mental health, learning disabilities, occupational therapies and much, much more. The health professionals represented include doctors, nurses, occupational therapists, radiologists, health care assistants and technicians. The regulatory body of most disciplines has its own guidance on working within the MCA.

Many NHS bodies which operate in Gateshead have robust MCA systems in place, and extremely skilled and knowledgeable practitioners. Those working in dementia, acquired brain injury, mental health or learning disability settings utilise the MCA on a daily basis. However, the legislation can be very difficult to negotiate for acute health staff who may need to apply it less often. A district nurse needs to understand the legal authority afforded to her by the MCA if, for example, she arrives to change a normally capacitous patient’s wound dressing, and finds him refusing, but also showing signs of delirium through infection.
A major challenge, then, for NHS bodies, is equipping such a wide and varied workforce to have the appropriate level of knowledge and to understand how to access timely advice. In an area where the concept of consent is key, how many practitioners understand that consent must be capacitous, and how to go about assessing this when needed?

The government is keen to design a patient driven NHS, based on choice and control. Particular consideration needs to be given to how to engage and represent the increasing numbers of people who may lack capacity or need additional support in order to make their own health care choices.

Consideration of mental capacity issues is given within the government’s response to its consultation on “Liberating the NHS: No decision about me, without me”, which states:

“In cases where people’s capacity is predicted to deteriorate over time, for example if they are diagnosed with early stage dementia, personalised care plans would be a useful way to enable them to plan how they would like their health needs met when they lose capacity. They will also be an important tool to help those who have fluctuating capacity retain more control when they become unwell. When planning care with people who lack mental capacity, it is important that the person be supported to have the fullest input possible into decisions affecting them. Their family, carers and representatives should also be fully involved in developing the plans for the future.”

“Liberating the NHS: No decision about me, without me”, and the NHS “2013/14 Choice Framework” can be downloaded from:

https://www.gov.uk/government/publications/
2.3 Independent advocacy providers

Advocacy reaches out to some of the most marginalised and disadvantaged sections of the community, people that formal services and systems can overlook: People who may be isolated in their own home, care homes or hospitals; or who lack confidence to speak up because they have been ignored or abused in the past; or lost faith in services; or are unaware that services and support exist. Many of these people either lack capacity about certain decisions, or require additional support to make their own decisions.

Independent advocacy is different to the support which may be provided by friends, family and professionals, because advocates are independent of the family dynamic or institutions which are providing services to the person. Demand for all types of advocacy is increasing dramatically. Independent advocacy providers need to be able to recruit and train skilled and assertive advocates who can work in partnership with people who have conditions which may affect their mental capacity, enabling them to say what they want, secure their rights, represent their interests and obtain the services they need.

Discussion of the Independent Mental Capacity Advocacy (IMCA) service takes place in the guidance section of this document, however, it must be recognised that the IMCA remit is narrow, and in many cases an IMCA may not be able to get involved. The advocacy needs of people who lack capacity or require additional support to make capacitated decisions are not limited to statutory IMCA, and can be served by many other types of advocacy.

Advocacy providers can be instrumental in enabling every person to have a voice of their own and ensuring that they are not excluded because they do not express their views or communicate in conventional methods. Many people with mental capacity issues are good at speaking up for themselves, but sometimes find it hard to get others to accept this or to listen to them. Self advocacy groups are a good way of encouraging this. They are groups of people who use services or have the same interests locally, working together to make sure they have a say in how those services are run. They are a very good way for people to support each other and they can help to build confidence so that people feel more able to speak up for themselves.

Non-instructed advocacy is a practical manifestation of the commitment to safeguarding the rights of the most vulnerable people and has emerged from within the wider advocacy context because of the MCA’s creation of the IMCA service. In many cases, advocacy work with people who lack capacity will take the form of non-instructed advocacy: taking affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person’s rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for their unique preferences and perspectives. Where a service user cannot give clear instruction, the advocate must:

- take time to get to know them and build a picture of their preferences and lifestyle including their cultural background
- seek appropriate alternative forms of communication which enable the service user to express views and choices and ensuring the person’s fundamental human rights are respected and upheld at all times
- challenge service providers and decision makers in order to promote a person centred approach act as a ‘witness’ or observer in the settings in which the service user spends time.

Gateshead Advocacy Information Network (GAIN) is a project of Gateshead Voluntary Organisations Council (GVOC) and it’s website can be accessed at: http://www.gain.org.uk/

GAIN’s vision is to make sure every citizen in Gateshead has access to an independent advocate if they need one. GAIN works in partnership locally with:

- Age UK Gateshead
- Alzheimer’s Society
- Gateshead Access Panel
- Gateshead Autism Group
- Gateshead Carers Association
- Gateshead People
- North Regional Association for Sensory Support (NRASS)
- Pathways Advocacy (at Mental Health Matters)
- Sight Service
- Your Voice Counts
2.4 The North East Ambulance Service (NEAS)

The North East Ambulance Service is also an NHS body, which provides paramedic interventions and patient transportation, both in planned and emergency situations. Since 2011, NEAS has made MCA training mandatory for all frontline operational staff and all contact centre staff. Their training includes an introduction to the Mental Capacity Act’s code of conduct and training on how to conduct a mental capacity assessment.

NEAS staff may attend patients who refuse their interventions. At these times, ambulance crew will need to make an assessment of capacity to determine how to proceed. A form, NEAS 84, is available to record the capacity assessment of a patient, and an on-call clinician is always available for staff to access advice.

If the person lacks capacity, interventions may need to be provided in their best interests. The ambulance crew should try to persuade the patient to cooperate with them using necessary and proportionate restraint. If the incapacitated patient continues to actively resist and there is a significant risk of injury to either the patient or themselves they should request the assistance of Northumbria Police.

If the person has capacity, their refusal must be respected. NEAS operates a ‘Patient Not Conveyed’ policy which instructs front line ambulance staff to ensure that patients who refuse treatment are informed fully of the risks and benefits of doing so. In these circumstances, the refusing, capacitous patient is asked to sign the ambulance record to evidence that they have refused treatment. If they are unable to or refuse to sign, ambulance crew will ask a witness to do so where possible.

NEAS has a database which contains details of people who have made valid advance decisions to refuse treatment, for example, those who do not wish to be resuscitated in the event of their death, or who wish to receive ‘end of life’ care and treatment in their own home. This enables the wishes of these individuals to be highlighted so that front line ambulance staff can act upon them.

2.5 Northumbria Police

Northumbria Police have a responsibility to respond to allegations of offences against vulnerable adults who lack capacity and to reports of concern for their welfare. It is their role to investigate promptly and thoroughly and decide firstly if a crime has been committed, and if so to gather evidence and present that evidence to the Crown Prosecution Service in order to bring offenders to justice.

All reports of serious crimes against vulnerable adults, including allegations of physical, sexual abuse and cases involving section 44 of the MCA - the ill-treatment or wilful neglect of a person who lacks capacity to make relevant decisions, are now investigated by the specialist Officers within the Protecting Vulnerable Persons (PVP) department. However, in many cases the Police are required to respond to emergency situations where the victim and sometimes the perpetrator lack capacity and in these cases Officers will need to make immediate decisions while awaiting further assessment by a health or social care professional. Where Police are the only service on scene it may be necessary to make an assessment of capacity and act accordingly before other services arrive due to the seriousness or urgency of the situation and in generally in order to ensure the safety of that person or another. If the MCA is used, the Officers should ensure that they record the steps they took to establish the person lacked capacity. When a doctor, member of the ambulance service or other professional arrives on the scene, or is already present, Police should defer to their expertise and provide support as appropriate.

The Police must have regard to guidance on Achieving Best Evidence (ABE) and the capacity of a person to consent to an interview must be assessed by the Police officer proposing to conduct that interview in accordance with that Guidance and the principles of the Mental Capacity Act.

In 2010, the national Police Improvement Agency (NPIA) produced “Guidance on responding to people with mental ill health or learning disabilities”. This document gives thorough consideration of the Police’s role and responsibilities under MCA, and provides guidance on when Officers should undertake the relevant provisions of the Act. The NPIA guidance is available to download from: www.npia.police.uk/

Northumbria Police need to be able to respond appropriately and investigate situations where the victim and sometimes the perpetrator of a crime lack capacity. They may be involved in investigations which lead to prosecution under Section 44 of the MCA - ill-treatment and wilful neglect of a person who lacks capacity to make relevant decisions.
The critically acclaimed MentalHealthCop is a blog written by a serving Police Inspector considering the dilemmas and operational issues at the interface of Policing and Mental Health. It provides a wealth of resources, quick guides and discussions around Policing and the MCA. It can be accessed at: http://mentalhealthcop.wordpress.com/about/

2.6 The Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them.

A death whilst subject to the Deprivation of Liberty Safeguards is classed as a death in custody, and therefore the Coroner’s office must be informed. The Coroner may have specific questions arising from the death of a person subject to DoLS authorisation, and the MCA Coordinator will work with the Coroner’s office to provide all required information.

2.7 Commissioners

“The Mental Capacity Act 2005… is designed to promote the empowerment of individuals and the protection of their rights. The Act underpins health and social care commissioning and practice.”

SCIE, November 2012

Commissioners of services should set out clear expectations of provider agencies and monitor compliance. Commissioners have a responsibility to:

- ensure that agencies from whom services are commissioned know about and adhere to the provisions of the MCA including the DoLS
- ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to the
- requirements of the Mental Capacity Act
- ensure that managers are clear about their leadership role in implementing and complying with the Mental Capacity Act by ensuring that quality of the service and the supervision and support of staff
- ensure staff have received induction and training appropriate to their levels of responsibility
- ensure that Mental Capacity Act considerations are always included in the monitoring arrangements for contracts and service-level agreements

The CQC published its 3rd annual report into the operation of the DoLS in March 2013. It made the following recommendations and observations:

- Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the DoL Safeguards.

“Training in the MCA and the safeguards is still patchy and not always reflected in improvements in practice… Understanding the Mental Capacity Act and the way it is applied is critical to good quality, safe care. Those providing services must ensure that their staff understand the Act and what it means for the care and treatment of people.”

- Providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experiences of people subject to the DoL Safeguards.

“CQC’s inspectors saw examples of friends and relatives being excluded from best interests decision-making, contrary to the requirements of the law… The use of care plans, recording of incidents and gathering of feedback from staff, people who use services and their relatives all need to improve… Providers and commissioners must go to greater lengths to consult with relatives and friends as part of the process when using the safeguards.”
2.8 The Crown Prosecution Service (CPS)

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. The CPS has produced a number of guidance documents which consider victims and witnesses of crime who may have issues with mental capacity.

The guidance can be downloaded from: http://www.cps.gov.uk/publications/prosecution/

The CPS states that it is important to recognise that the competence of a witness is a separate issue to that of the mental capacity of a witness. It is also important not to make assumptions about the credibility or reliability of a witness. Prosecutors and police should discuss, at an early stage, whether the witness is likely to be accepted as a competent witness by the courts, taking into account information provided by others, for example, a doctor, family members, or a social worker etc.

The Youth Justice and Criminal Evidence Act 1999 sets out the general rule that people are competent to act as witnesses unless they cannot understand questions asked of them at court and answer them in a manner which can be understood (with, if necessary, the assistance of special measures).

Mental capacity is only relevant to the competence of the witness in terms of assessing the witness’ ability to understand questions asked and to give replies that can be understood.

Medication issues may be relevant when considering the timing of giving evidence and the need for maximum lucidity. This factor may be equally relevant to any witness taking medication, whether mental capacity is an issue or not.
3.1 Assessing Capacity

Presumption of Capacity - The starting point of the Act is to confirm in legislation that anyone (aged 16 or over) has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make decisions for themselves at the time the decision needs to be made.

Prejudicial assumptions regarding such things as the service user’s age, appearance, condition or behaviour must be avoided when considering capacity.

The Act also states that individuals must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision making process.

A person is defined as lacking capacity (Section 2 of the MCA), when, if at the material time he/she is unable to make a decision for him/herself in relation to a matter because of an impairment of, or a disturbance in the function of the mind or brain. Whether a person lacks capacity or not will be decided on the balance of probability.

Who should assess capacity?

The person who is proposing the care, treatment or action, for example:

- A care worker should assess whether a person has capacity to consent to them providing personal care.
- A police officer should assess whether a person has capacity to be interviewed in connection with an alleged offense.
- A paramedic should assess whether someone has capacity to consent or refuse to be conveyed to hospital by ambulance.
- A housing officer should assess whether a person has the capacity to enter into a tenancy agreement.
- A solicitor should assess whether someone has capacity to make a will.
- A doctor should assess whether someone has capacity to consent to or refuse medical treatment.
- A treating clinician or AMHP should assess a person’s capacity to consent to “informal” admission to a psychiatric unit.
- If the decision is more complex, or serious, there will be a need for a more thorough assessment, possibly involving a psychiatrist, speech and language therapist or a team of people.

How should capacity be assessed?

The flow chart on the next page maps the basic process of assessing capacity.
Capacity Assessment Process

Is there a specific decision to be made?

Yes

Is there evidence of impairment or disturbance of the functioning brain or mind?

Yes

Are there some times when the person is more capable of making a decision?

No

Yes

Plan to carry out the assessment to take place when the person is at their best

The person makes the decision

No

Carry out the assessment:

- Interview the person
- Get help with communication if necessary
- Involve family, friends etc as appropriate
- Involve other professionals

Don’t rush the decision making - be prepared to try more than once.

- Can the person understand the information?
- Can they retain the information?
- Can they weigh up the information?
- Can they communicate their decision?

If YES to all of these questions

The person has capacity and therefore makes their own decision

Document that the person has been assessed as having capacity using

- MCA1 form or equivalent
- Case notes
- Care plan

If NO to any of these questions

The person does not have capacity

Document that the person has been assessed as lacking capacity using

- MCA1 form or equivalent
- Case notes
- Care plan

Go to Flowchart 2
Making a Best Interests Decision for someone who lacks Capacity
Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.

Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury, and
- the symptoms of alcohol or drug use.

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

It is important not to assess someone's understanding before they have been given relevant information about a decision. Assessing capacity should be a process of effective communication skills. Every effort must be made to provide information in a way that is most appropriate to help the person to understand. Quick or inadequate explanations are not acceptable unless the situation is urgent. Relevant information includes:

- the nature of the decision
- the reason why the decision is needed, and
- the likely effects of deciding one way or another, or making no decision at all.

The information must be presented in a way that is appropriate to meet the individual's needs and circumstances. For example:

- a person with a learning disability may need somebody to read information to them. They might also need illustrations to help them to understand what is happening. Or they might stop the reader to ask what things mean. It might also be helpful for them to discuss information with an advocate
- a person with anxiety or depression may find it difficult to reach a decision about treatment in a group meeting with professionals. They may prefer to read the relevant documents in private. This way they can come to a conclusion alone, and ask for help if necessary.
- someone who has a brain injury might need to be given information several times. It will be necessary to check that the person understands the information. If they have difficulty understanding, it might be useful to present information in a different way (for example, different forms of words, pictures or diagrams). Written information, audiotapes, videos and posters can help people remember important facts.

Carers or other family members may sometimes exert pressure on staff to treat a person as lacking capacity to take certain decisions and to care for them as the family would wish. Staff must not be influenced by such pressure, but must instead reach their own view as to the person's capacity by applying the principles set out in the MCA, the Code of Practice and this document.

A person is unable to make a decision if they cannot:

1. understand information about the decision to be made (the Act calls this 'relevant information')
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision (by talking, using sign language or any other means).
If the person is deemed to have capacity under the meaning of the Act then they are entitled to make their own decision. If not, a Best Interests decision will need to be made.

Gateshead Council has a form for staff to record Mental Capacity assessment, which is called MCA1. Many agencies have their own form, and some professionals prefer to write a report, or make a detailed entry in the person’s care records. All of these methods of recording are acceptable.

It is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. So assessments should be reviewed from time to time. Capacity should always be reviewed:

● whenever a care plan is being developed or reviewed
● at other relevant stages of the care planning process, and
● as particular decisions need to be made.

Full guidance on assessing capacity can be found in Chapter 4 of the MCA Code of Practice.

3.2 Consent and Capacity

The issues of consent and capacity are closely linked. Consent enables interventions to lawfully take place on the basis the person is adequately informed, has the capacity to consent, and is free from coercion. The seeking or giving of consent is a process rather than a one off event. The validity of consent does not depend on the form in which it is given.

Acquiescence where the person does not know what the intervention entails is not consent. Where any doubt about the patient’s capacity to consent exists the health professional should assess the capacity of the patient to take the decision in question.

No-one is able to give consent to the examination or treatment of an adult unable to give consent for him or herself. Therefore, carers, relatives or members of the healthcare team cannot consent on behalf of such an adult although they can contribute to the decision making process. The key principle concerning treatment will be what is in their Best Interests, recognising that these are not confined to medical Best Interests.

In respect of mental health, the Mental Health Act 1983 provides a legal framework by which a detained patient’s treatment may be made compulsory in the absence of their consent or their refusal to consent. However, the patient’s consent should always be sought and their mental capacity and consent or refusal should be recorded in full.

When patients are detained under the Mental Health Act, they may be given treatment with medication for their mental disorder for the first three months of their treatment, even if they refuse to consent or are incapable of giving consent to that treatment. After this time (except in emergencies), the treatment can be given only under certain conditions and the authority for that treatment must be formally certified.

Where the patient consents to the treatment, either the Approved Clinician in charge of it or a Second Opinion Appointed Doctor (SOAD) will certify that consent on a statutory form, where the patient lacks capacity to consent, or refuses to consent, the treatment may only be given following a SOAD’s certification, on a statutory form, that is appropriate for it to be given. A patient’s capacity and consent status should be under continuous review, especially when they have been certified as consenting to treatment by the clinician in charge of treatment.

3.3 Best Interests

An essential foundation of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests and not on the basis of any unjustified and prejudicial assumptions.

The Act requires that any Best Interest decision or act must be the least restrictive option to the person in terms of their rights and freedom of actions. The Act recognises the right of a capacitated individual to make what may be considered by others to be an unwise decision.

The following are some examples of Best Interests decisions that must always be formally recorded:

● All decisions as to the care and treatment (beyond matters of day to day personal care and normal activities of daily living).
● Medical treatment
● Care planning
● Decisions as to ongoing care which will be subject to future review;
● Issues of dispute with family members or other interested parties;
● Changes of accommodation

Section 4 of the Act sets out a non-exhaustive checklist of factors to take into account when considering Best Interests. The decision maker needs to consult with family and close friends, professionals and anyone else involved with the person in order to make a Best Interest decision. Where the decision maker needs to balance a range of views simultaneously or there are several interrelated decisions to be made, a meeting may be the most appropriate forum.

In emergency situations, staff have less time to come to a conclusion about the steps above so it will almost always be in the person's Best Interests to give emergency treatment. Section 5.39 of the Code of Practice makes it clear that learning about a person's past and present views depends on circumstances and that what is available in an emergency will be different to what is available in a non-emergency. However “...even in an emergency there may still be an opportunity to try to communicate with the person or his friends, family or carers.

The views of all parties consulted, including the person deemed as lacking capacity to make the particular decision, need to be considered and recorded as part of the Best Interest decision making process. Sometimes there might be disagreement or dispute as to what would be in the best interests of an incapacitated person, for example between clinicians and family members. In the event of a dispute staff should seek local resolution if at all possible. The following may assist the decision maker to resolve the dispute:

● Involve an advocate who is independent of all parties involved
● Get a second opinion as to capacity and/or best interests
● Hold a strategy meeting of all involved
● Consider mediation.

The flow chart on the next page maps the basic process of making a best interests decision.

Where local resolution of a dispute is not possible despite all efforts of the decision maker, consult with line management and seek a legal perspective should be obtained. The Court of Protection has jurisdiction to resolve disputes as to the capacity and/or best interests of an incapacitated person.

Gateshead Council has a form for staff to record Best Interests Decisions, which is called MCA2. Many agencies have their own form, and some professionals prefer to write a report, or make a detailed entry in the person’s care records. All of these methods of recording are acceptable. Recording should be completed each time a new best interests decision is required; this will be included each time there is a change in the proposed treatment regime or care plan.

Full guidance on making best interests decisions can be found in Chapter 5 of the Code of Practice.
**Best Interests Decision Making Process**

**Decision makers vary according to:**
- Type of decision
- Individual’s Circumstances

**Decision makers may be:**
- A care worker
- A nurse
- A family member
- A doctor
- A solicitor or lawyer etc

**Is there an Advance Decision or LPA?**
- **Yes**
  - Best Interests Decision made with regard to Advance Decision or LPA
- **No**
  - **Significant Decision**
    - Person has a relative or carer able to represent their views?
      - **Yes**
        - Gather information from all available sources. If possible, hold a Best Interests meeting
        - Consult and involve anyone named by the person and all key people – even if they have opposing views
        - Key people could be family, friends, care staff, social workers, solicitors
      - **No**
        - Instruct an IMCA if the decision relates to:-
          - Serious medical treatment
          - Change of accommodation
          - Review of accommodation
          - Safeguarding adults’ proceedings
          - Consider an advocate for all other decisions
        - Make a Best Interests decision, giving consideration to least restrictive option.
        - If there is strong opposition to the Best Interests decision, an application to the Court of Protection should be considered
        - Document using MCA2 or equivalent. State:
          - Who you consulted
          - What options were considered
          - Any disagreements/conflicts
          - What the decision is
          - Why it was reached
          - When it should be reviewed

  - **Day to Day Decision**
    - Act in the person’s best interests and document that you have done so in the:
      - Case Notes
      - Care Plan
3.4 Covert medication

Covertly medicating a person is giving them medication without their knowledge, usually mixed into their food or drink. The issue of covert medication is controversial, and each organisation should refer to their own policy.

There are situations when covertly administering medication may be found to be in a person’s best interests, but a robust capacity assessment and best interests process must be followed. In almost every case the decision maker would be the prescriber. Consideration must be given to

- Whether the medication is essential – what harm is the person likely to come to if they don’t receive it?
- Whether the medication available in an alternative form (e.g. liquid) that would be acceptable?
- Palatability, safety and stability of medicines.
- Whether the chemical components would be altered if it should be crushed or capsule split.

3.5 Protection from liability

The MCA 2005 offers protection to those performing acts of care or treatment in the Best Interests of a person who lacks capacity to consent to that act, providing they have followed the MCA 2005 and the Code. Staff must be able to demonstrate that they reasonably believe that person lacks capacity and the act is in their Best Interests. If the decision is challenged the person will have to be able to provide objective reasons for their reasonable belief. It is vital that the person clearly records the reasons for their decision/actions.

Care and treatment includes things like

- providing nursing care or social care,
- providing personal care
- carrying out diagnostic examinations and tests,
- providing professional medical treatment
- prescribing or giving medication,
- providing emergency care,
- carrying out necessary medical procedures and therapies
- and arranging to refer someone to hospital for an assessment or for treatment.

The protection does not apply to an act which is negligently performed, or which may give rise to criminal liability. There are certain limitations on the legal protection that the MCA provides. In particular:

- **Restraint**
  - Actions which involve restraint of a person who lacks capacity will only be justifiable under the MCA where certain further conditions are satisfied (see below)

- **Deprivation of liberty**
  - The MCA does not allow staff to deprive a person who lacks capacity of their liberty outwith the Deprivation of Liberty Safeguards.

- **LPAs**
  - Where an attorney has been appointed under a Lasting Power of Attorney to take health and welfare decisions, staff must not act contrary to a decision made by that attorney, as long as the attorney is acting within the scope of his/her authority (see below)

- **Deputies**
  - Where the court has appointed a deputy to take health and welfare decisions, staff must not act contrary to a decision made by that deputy, as long as the deputy is acting within the scope of his/her authority. Below

- **Advance decisions**
  - Where a person has made a valid and applicable advance decision, staff must not act contrary to that advance decision, even if they believe it would be in the incapacitated person’s best interests to do so.

Further guidance on protection from liability can be found in Chapter 6 on the MCA Code of Practice.

3.6 Restraint

The MCA defines someone as using restraint if they

“use force, or threaten to use force, to make someone do something they are resisting, or where a person’s freedom of movement is restricted, whether they are resisting or not.”

Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do. For example:

- **Physical restraint** — holding someone to prevent them from leaving a room or building.

- **Chemical restraint** — giving someone sedative medication to prevent them from leaving a room or building.
Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty are physical abuse. There is a distinction to be drawn between restraint, restriction and deprivation of liberty. A judgement as to whether a person is being deprived of liberty will depend on the particular circumstances of the case, taking into account the degree of intensity, type of restriction, duration, the effect and the manner of the implementation of the measure in question. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence.

However, at times restraint can be an appropriate course of action for someone who lacks capacity, in order to prevent them from harm, or to make sure that they receive treatment that they need. Restraint should not be viewed as abusive as long as it can be evidenced that it is:

1. necessary to prevent harm to a person who lacks capacity and
2. a proportionate response to the likelihood and seriousness of the harm.

Providers of health and social care must have in place internal operational procedures covering the use of physical interventions and restraint. Care plans and behavioural management plans should clearly evidence the person’s lack of capacity, the views of those consulted and involved in the decision to use restraint in the person’s best interests, the situations in which restraint will be used, and the type and duration of restraint.

Further guidance on restraint can be found in Chapter 6 of the MCA Code of Practice.

### 3.7 Payment for goods and services

If a person lacks capacity to arrange for payment for necessary goods and services, the MCA allows a person to arrange payment on their behalf. ‘Necessary’ means something that is suitable to the person’s condition in life (rather than any mental or physical condition) and their actual requirements when the goods or services are provided. The aim is to make sure that people can enjoy a similar standard of living and way of life to those they had before lacking capacity – if they can still afford it.

The carer must first take reasonable steps to check whether a person can arrange for payment themselves, or has the capacity to consent to the carer doing it for them. If the person lacks the capacity to consent or pay themselves, the carer must decide what goods or services would be necessary for the person and in their best interests. The carer can then lawfully deal with payment for those goods and services in one of three ways:

- If neither the carer nor the person who lacks capacity can produce the necessary funds, the carer may promise that the person who lacks capacity will pay. However the carer may not be comfortable with this, and equally the supplier may not be willing to accept this arrangement.
- If the person who lacks capacity has cash, the carer may use that money to pay for goods or services (for example, to pay the milkman or the hairdresser).
- The carer may choose to pay for the goods or services with their own money. If so, the person who lacks capacity must pay them back. This may involve using cash in the person’s possession or running up an IOU. Someone with legal authority to handle the person’s financial affairs may need to be approached to obtain reimbursement.

Carers must keep bills, receipts and other proof of payment when paying for goods and services. They will need these documents when asking to get money back.

The Act does not give a carer or care worker access to a person’s income or assets. Nor does it allow them to sell the person’s property. Anyone wanting access to money in a person’s bank or building society will need formal legal authority (e.g. a Lasting Power of Attorney or Court Order).

Sometimes another person will already have legal control of the finances and property of a person who lacks capacity to manage their own affairs. This could be an attorney acting under a registered Enduring Power of Attorney or an appropriate Lasting Power of Attorney, or a deputy appointed by the Court of Protection. Alternatively it could be someone that has the right to act as an ‘Appointee’ (under Social Security Regulations) and claim benefits for a person who lacks capacity to make their own claim and use the money on the person’s behalf. The MCA makes clear that a carer cannot make arrangements for goods or services to be supplied to a person who lacks capacity if this conflicts with a decision made by someone who has formal powers over the person’s money and property, such as an attorney or deputy acting within the scope of their authority.
The British Banking Association (BBA) has produced a useful guide to the options for managing a bank account for someone else.

Guidance for people wanting to manage a bank account for someone else

This can be downloaded from:
http://www.bba.org.uk/media/article/new-help-for-people-who-have-to-manage-an-account-for-someone-else

Further guidance on payment for goods and services can be found in Chapter 6 of the MCA Code of Practice.

3.8 Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs)

A Lasting Power of Attorney (LPA) is a legal document that allows a person who has capacity to appoint one or more people to act for them, if in the future that person becomes incapable of managing for themselves. It must be created while the person has capacity and is capable of understanding the nature and effect of an LPA.

There are two types of LPA:

1. A Property and Affairs LPA – which gives the attorney authority to make decisions about financial affairs;

2. A Personal Welfare LPA – which gives the attorney authority to make decisions about healthcare and personal welfare.

An important distinction between the two types is that, with the donor’s agreement, a property and affairs LPA can be registered and used by the attorney even when the donor still has mental capacity to make their own decisions. A personal welfare LPA can only be registered and used once the donor has lost capacity to make the relevant decisions themselves.

The LPA system is wider ranging than the previous system of Enduring Powers of Attorney, as an EPA can only cover financial decisions, not decisions on health care or personal welfare. Existing Enduring Powers of Attorney are still valid, even if they were not registered before 1st October 2007. If an individual made an EPA before 1st October 2007 and wants to replace it with an LPA, they can do so as long as they have the capacity to make that decision.

Where a person is acting as an attorney under a personal welfare LPA, they will be entitled to take decisions regarding the health and social care of the incapacitated person that appointed them; as long as they act within the scope of the authority they have been given. Health and social care staff will be required to go along with the decisions the attorney takes. However, a personal welfare attorney will only be able to take decisions regarding life sustaining treatment where they have been granted the specific authority to do so by the incapacitated person in the LPA document.

An attorney cannot refuse their consent to treatment given to a detained patient under Part IV of the Mental Health Act 1983.
All LPAs must be registered with the Office of the Public Guardian when they are created. An LPA has no effect unless it has been registered in this way. When dealing with a person who claims to be the valid attorney of an incapacitated person under an LPA, staff should ask to see a copy of the LPA which has been stamped on every page by the Office of the Public Guardian to confirm that it has been registered. Staff should also check the stamped LPA to confirm the nature and extent of the attorney’s authority to take decisions. If the LPA or EPA is not physically present, staff can complete the application for a search of the register via the Office of the Public Guardian’s website: http://www.publicguardian.gov.uk/.

Further information on Lasting Powers of Attorney can be found in Chapter 7 of the MCA Code of Practice.

3.9 The Office of the Public Guardian (OPG)

The OPG was established under the Mental Capacity Act to support the Public Guardian and to protect people lacking capacity by:

- setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies
- supervising deputies
- sending Court of Protection visitors to visit people who lack capacity and also those for whom it has formal powers to act on their behalf
- receiving reports from attorneys acting under lasting powers of attorney and deputies
- providing reports to the Court of Protection
- dealing with complaints about the way in which attorneys or deputies carry out their duties.

The OPG can carry out an investigation into the actions of a deputy, of a registered attorney (lasting powers of attorney or enduring powers of attorney) or someone authorised by the Court of Protection to carry out a transaction for someone who lacks capacity, and report to the Public Guardian or the court.

How the investigation is carried out will depend on the particular circumstances, but will typically involve contact with people and agencies that have contact with the person. Local authorities can use the OPG protocol to refer concerns to the OPG relating to anyone who falls within the OPG definition of an Adult at Risk.

The OPG will refer all concerns and allegations relating to people not covered by the OPG Safeguarding Vulnerable Adults Policy to the relevant adult social care service. Where it is considered that a crime has or may have been committed, a report will be made to the police.

Further information on the OPG can be found in Chapter 14 of the MCA Code of Practice and by accessing: http://www.publicguardian.gov.uk/.

3.10 Court of Protection

The Court of Protection is an Office of the Supreme Court. The Court’s jurisdiction extends to England and Wales. Separate arrangements exist for Scotland and Northern Ireland.

The Court of Protection deals with decisions and orders affecting people who may lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- decide whether a person has capacity to make a particular decision for themselves
- make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make such decisions
- make declarations regarding deprivations of liberty in circumstances where the Mental Capacity Act Schedule A! does not apply
- appoint deputies to make decisions for people lacking capacity to make those decisions
- decide whether an advance decision, lasting power of attorney or enduring power of attorney is valid
- remove deputies or attorneys who fail to carry out their duties.
- Exercise the inherent jurisdiction of the High Court in respect of people who, while they may have capacity, have been subject to coercion so that they cannot freely exercise their own will to achieve what is in their best interests.

In a situation where a person does not have mental capacity and does not have anyone to act for them, the court can appoint a deputy to take decisions on welfare, healthcare and financial matters. When dealing with a person who claims to be the court-appointed deputy of an incapacitated person, staff should ask to see a copy of the sealed court order which gives the deputy their authority. Staff should also check the order to confirm the nature and extent of the attorney’s authority to take
decisions. All deputies are provided by the Court of Protection with extra copies of the order to demonstrate their authority when required.

In most cases, decisions about personal welfare can be made legally without making an application to the court, as long as they are in accordance with the core principles set out in the Mental Capacity Act 2005 and any disputes or disagreements can be resolved informally. However, it may be necessary and desirable to make an application to the court in a situation where there are:

- particularly difficult decisions to be made, for example where there is a fine balance of risks and benefits to the person from a particular course of action and the results would be serious
- disagreements that cannot be resolved by any other means
- ongoing decisions needed about the personal welfare of a person who lacks capacity to make such decisions for themselves
- matters relating to property and/or financial issues to be resolved
- serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration
- concerns that a person should be moved from a place where they are believed to be at risk, or a desire to place restrictions on contact with named individuals because of risk or where proposed Safeguarding Adults actions may amount to a deprivation of liberty outside of a care home or hospital.

When there is dispute between an incapacitated person’s family or carer and a local authority or NHS body about what is in a person’s best interests, and the matter cannot be resolved, then the burden is on the institution to make application to the Court of Protection.

Where someone suspects that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual, the Court should be the arbiter for matters of no contact. An authorisation under MCA DOLS, other than as a very short-term measure, should not be relied upon to manage no contact cases. The court should not only be accessed when there is a dispute, it should also be used to ensure that the person can access the additional safeguard that the courts have to offer for decision making.

In most cases where an application should be made to court this will be undertaken by Local Authority or NHS Trust, however, in accordance with the first principle of the Act, it should not be assumed that the person is unable to make an application to the court themselves.

Where a person does not have capacity to instruct a solicitor, a litigation friend should be appointed. A person acting as a litigation friend can instruct a solicitor on the person’s behalf. The Official Solicitor can act as a litigation friend of last resort for people who lack capacity and do not have anyone else who can undertake the role.

A Safeguarding or Multi-disciplinary meeting will usually determine whether an application to the Court of Protection in relation to only Personal Welfare or both Personal Welfare and Property and Affairs is required. An Adult Services Solicitor or NHS legal rep must have provided advice in relation to the basis for the application(s).

More guidance on the Court of Protection can be found in Chapter 8 of the MCA Code of Practice.

3.11 **Advance decisions to refuse treatment**

The Act creates statutory rules with clear safeguards so that people over 18 years of age may make a decision in advance to refuse treatment if they should lack capacity in the future. If a treating professional is aware of an applicable and valid advance decision to refuse treatment, they cannot act against it.

Encouragement should be given to any individual to put their wishes in writing and to inform those closest to them of the existence of such a document. Staff should alert any person stating a particular wish of the difficulties of a verbal Advance Decision. The decision around the existence, validity and applicability of an Advance Decision is for the health professional to make.

Where an Advance Decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the Advance Decision to be applicable. These formalities are that the decision must be

- in writing
- contain an explicit statement that the decision stands “even if life is at risk”.
- be signed and witnessed.
In general, an advance decision may be withdrawn or altered by the person who made it at any time by any means. However, in the case of an advance decision to refuse life-sustaining treatment, any withdrawal or alteration must be made in writing.

Health and social care staff must abide by an advance decision that is both valid and applicable, unless treatment is to be given under Part IV of the Mental Health Act 1983. An advance decision will be valid where it has been made in the correct form and where there is no reason to doubt that it reflects the genuine wishes of the incapacitated person at the time they had capacity in relation to the matter. An advance decision will be applicable where:

- It sets out clearly the treatment that is being refused and the circumstances in which it is to be refused, and
- The treatment proposed is the same treatment set out in the advance decision, and the circumstances are the same as in the advance decision.

There may be reason to doubt the validity of an advance decision where:

- There is evidence that it was revoked by the incapacitated person whilst they still had capacity, or
- There is evidence that the incapacitated person changed their mind about the matter whilst they still had capacity, or
- There is evidence that the incapacitated person made the advance decision under duress or coercion, or
- Since making the advance decision the incapacitated person appointed an attorney under an LPA with authority to take decisions in relation to the same matter.

Further guidance on Advance Decisions to Refuse Treatment can be found in Chapter 9 of the MCA Code of Practice.

### 3.12 Advance Statements

An advance statement is a document which is completed by a patient, at a time when they have the necessary mental capacity, to make known their wishes regarding care, treatment and other personal matters should they become unwell.

Unlike an advance decision, an advance statement will not set out to specify which types of care or treatment the person does not want to receive if they should lose capacity in the future. If a person wishes to stipulate which types of treatment they should not be given when they lack capacity, they should be advised to make a valid and applicable advance decision, bearing in mind the relevant provisions of the MCA and the formal requirements discussed above.

The purpose of an advance statement is to:

- set out the person’s wishes and preferences in terms of care and treatment
- identify those trusted relatives, carers and/or advocates who may be contacted in an emergency or consulted with by professionals;
- indicate what practical arrangements the individual may wish to have addressed if admitted to care or hospital, e.g. regarding care of dependents, safeguarding their home and managing their possessions.

Unlike an advance decision, an advance statement will not be legally binding upon health or social care professionals. However, the MCA states that when reaching a best interests decision concerning a person who lacks capacity, a decision maker must have regard to any relevant written statements made by that person at a time when they had capacity. Decision makers will therefore be under a duty to consider the content of an advance statement when reaching a best interests decision.

An advance statement is a document that a person can write themselves, with help from any other person. It can be written as part of a care review, or at any other time. Advance statements can be written in any format.

NHS North East has produced “Deciding Right”, a comprehensive guide to identifying the triggers for making care decisions in advance, and complying with both current national legislation and the latest national guidelines. At its core is the principle of shared decision making to ensure that care decisions are centered on the individual and minimise the likelihood of unnecessary or unwanted treatment.
Deciding right can be downloaded from:

3.13 The Independent Mental Capacity Advocacy (IMCA) Service

The MCA places a duty upon decision-makers to consult with those close to an incapacitated person when deciding what course of action might be in that person's best interests. However, some incapacitated people may not have anyone close to them (e.g. no close family or friends) with whom a decision maker might consult when deciding upon best interests.

The IMCA service was created by the MCA and commenced when the first part of the Act came into force in April 2007. The role of the IMCA service is to provide independent safeguards for people who lack capacity and are without family or friends to consult as part of certain important decisions and at the time such decisions need to be made. An IMCA is a specially trained advocate who represents the views and best interests of a person who lacks capacity by making representations about their wishes, feelings, beliefs and values. The IMCA will bring to the attention of the decision-maker all factors that are relevant to the decision. Unlike general or case advocates, IMCAs have a statutory right to see the incapacitated person alone, and to access relevant health and social care records.

Health and social care staff are under a duty to instruct an IMCA to represent and support an incapacitated person in the following circumstances:

**Serious medical treatment**

Where an NHS body is proposing to provide, or secure the provision of,

"serious medical treatment" for an incapacitated person, and where that NHS body is satisfied that there is no one other than a paid carer with whom it would be appropriate to consult in determining what would be in the person's best interests, an IMCA must be instructed to represent the patient.

Serious medical treatment is defined as treatment which involves providing, withdrawing or withholding treatment in circumstances where:

- There is a fine balance between the benefits and burdens/risks to the patient, or
- Where there is a choice of treatments, the decision as to which one is finely balanced, or
- What is proposed would be likely to involve serious consequences for the patient.
- However there will be no duty to instruct an IMCA where serious medical treatment is provided under Part IV of the Mental Health Act 1983.

**Long term accommodation by the NHS**

Where an NHS body proposes to accommodate an incapacitated person in a hospital (or move them to another hospital) for more than 28 days, or proposes to place the person in a care home (or move them to another care home) for longer than 8 weeks, and the NHS body is satisfied that there is no one other than a paid carer with whom it would be appropriate to consult in determining what would be in the person's best interests, an IMCA must be instructed to represent the patient.

However, there will be no duty to instruct an IMCA where accommodation is provided under Part IV of the Mental Health Act 1983.

**Long term accommodation by a local authority**

Where a local authority proposes to accommodate an incapacitated person in residential accommodation a care home (or move them to different residential accommodation) for more than 8 weeks, and the local authority is satisfied that there is no one other than a paid carer with whom it would be appropriate to consult in determining what would be in the person's best interests, an IMCA must be instructed to represent the patient.

However, there will be no duty to instruct an IMCA where accommodation is provided under Part IV of the Mental Health Act 1983.

An IMCA may also be instructed where the decision-maker is satisfied that having an IMCA will be of particular benefit to the person who lacks capacity in:

- a care review regarding an incapacitated person, or
- safeguarding adults proceedings involving an incapacitated person as either victim, perpetrator or both. Where the Local Authority or the NHS proposes to take or have taken protective measures in relation to a person who lacks capacity to agree to those measures.

And

The protective measures have been taken after receipt of an allegation or evidence that the person lacking capacity is being or has been
abused or neglected by another OR is / has abused another person

In safeguarding adult cases, access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends are still entitled to have an IMCA to support them in safeguarding adult procedures. The Safeguarding Adults Manager (SAM) must be satisfied that having an IMCA will benefit the person.

IMCAs can be instructed in other situations, for example, where the NHS body or local authority is in a dispute with the incapacitated person’s family about their best interests. This must be agreed with the MCA coordinator, who will give the IMCA provider authority to undertake extra-ordinary instruction.

The IMCA must decide how best to represent and support the person who lacks capacity that they are helping. They:

● must confirm that the person instructing them has the authority to do so
● should interview or meet in private the person who lacks capacity, if possible
● must act in accordance with the principles of the MCA and the Code of Practice
● may examine any relevant records that the MCA allows them access to
● should get the views of professionals and paid workers providing care or treatment for the person who lacks capacity
● should get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity
● should get hold of any other information they think will be necessary
● must find out what support a person who lacks capacity has had to help them make the specific decision
● must try to find out what the person’s wishes and feelings, beliefs and values would be likely to be if the person had capacity
● should find out what alternative options there are

● should consider whether getting another medical opinion would help the person who lacks capacity,
● must write a report on their findings for the local authority or NHS body that instructed them

The local authority or NHS body which instructed the IMCA must have regard for the IMCA’s report and must inform the IMCA service of the best interests decision reached, to enable to IMCA to challenge the decision-maker on behalf of the person lacking capacity if he/she does not agree with the decision that is ultimately reached.

The decision maker is legally required to have regard for the IMCA’s report, and the IMCA can challenge the decision maker on behalf of the person lacking capacity if necessary.

The Department of Health produces an annual report into the operation of the IMCA service, the most recent version of which can be downloaded from: https://www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-fifth-annual-report--2

Further guidance on the IMCA service can be found in Chapter 10 of the MCA Code of Practice.
3.14 Research

It is important that research involving people who lack capacity can be carried out and that it is carried out properly. Without it, we would not improve our knowledge of what causes a person to lack or lose capacity and the diagnosis, treatment, care and needs of people who lack capacity.

The Act sets out when research can be carried out, the ethical approval process, respecting the wishes and feelings of people who lack capacity. It includes other safeguards to protect people who lack capacity, how to engage with a person who lack capacity and how to engage with carers and other people.

Further guidance on research can be found in Chapter 11 of the MCA Code of Practice.

3.15 Considerations for children and young people

Robust joint working arrangements between children’s and adult services must be put in place to ensure that the independence, well-being and choice of children who will go onto become adults who may lack capacity are recognised and addressed as they move to adulthood.

The care needs of the young person should be at the forefront of any support planning and require a coordinated multi-agency approach. This can be complex to balance as between the ages of 16 and 18 the differing provisions of both the Mental Capacity Act and the Children Act are available.

Good practice includes:

- having policies and procedures which support effective transition processes
- shifting the general view of risk as a potential danger for a child, to one of potential opportunity but acknowledging potential risks for an adult
- managing risks as a phased process with awareness of the psychological and emotional issues
- managing family expectations (being clear about the level of support and resources available)
- taking time to get to know the young person and their family, especially if they have communication difficulties
- acknowledging the rights of adults to take more responsibility for their decisions.
- proactive planning in the ending of any legal orders (e.g., s31 Care Order) and whether any applications to the Court of Protection are required

3.16 Interface between the MCA and the MHA83

The Mental Health Code of Practice states: “It will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under the MHA83) without an understanding of key concepts in the Mental Capacity Act. It is important for health and social care staff who work with client groups with mental health problems, particularly those with severe and enduring mental illness to have an understanding of this interface. This also includes the need to have an awareness of the DoLS.

The relationship between the MCA and the MHA83 is complex. However, in general terms:

- Where a patient is detained under the MHA83, they can be given treatment for their mental disorder and for symptoms of that mental disorder without their consent. In these circumstances, the MCA will not apply and the provisions of Part IV of the MHA should instead be relied upon when determining whether to provide treatment.
- Where a detained patient requires treatment which is not for their mental disorder or any symptom of it (for example, treatment for a medical condition which is not related to their mental disorder), they cannot be provided with this treatment without their consent. In these circumstances, Part IV of the MHA cannot be relied upon in order to give treatment without the patient’s consent, and instead the provisions of the MCA will apply. Either the patient’s valid consent to treatment must obtained, or a best interests decision must be properly reached where the patient is assessed as lacking capacity to give their consent.
- Where a patient is not detained under the MHA, their valid consent to treatment is required and they cannot be treated without consent under Part IV. The provisions of the MCA will apply in full in these cases.

Chapter 13 of the MCA Code of Practice gives further guidance on the relationship between the MCA and the MHA.
3.17 Disputes

People may disagree about:

● A person’s capacity to make a decision.

● What is in the person’s best interests.

● A decision that someone is making on their behalf.

● An action someone is taking on their behalf.

It is in everyone’s interests to settle disagreements and disputes quickly and effectively, with minimal stress and cost. Consideration needs to be given to holding a meeting to clarify the areas of dispute, asking for a second opinion in relation to a decision on capacity or referring the matter to mediation.

It is important to remember that one side does not “trump” the other, and that disputes which cannot be resolved must be taken to the Court of Protection.

Further guidance on this matter can be found in Chapter 15 of the MCA code of practice.

3.18 Access to records

Staff need to be aware that there may be requests for access to a service user’s records or information from:

● Attorneys acting under a valid LPA or EPA.

● IMCAs. The request for information from an IMCA should be information relevant to the decision to be made in respect of which they have been appointed.

● Court of Protection Visitors.

● Relevant Persons Representatives, Best Interests Assessors and Mental Health Assessors under DoLS.

● The Court of Protection or High Court can also grant permission to the Official Solicitor’s representative and independent experts to view records.
4.1 Introduction

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) are a response to a European Court of Human Rights judgement in October 2004 – the case of HL v UK. The Court found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment, and who had been admitted informally to Bournewood Hospital, was unlawfully deprived of his liberty in breach of Article 5 of the European Convention on Human Rights (ECHR).

The MCA DoLS remedy this breach of the ECHR. They provide a framework for the lawful deprivation of liberty of those people who lack capacity to consent to arrangements made for their care or treatment in either a hospital or care home, and need to be deprived of liberty in their own best interests to protect them from harm. It is important to bear in mind however, that the deprivation of liberty authorisation (urgent or standard) relates solely to the issue of deprivation of liberty. It does not in itself give authority to treat people or to do anything else that would normally require their consent but provides a legal framework within the DoLS code of practice, by which that care or treatment might be legitimately provided. Those arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are subject to the wider provisions of the Mental Capacity Act 2005, as defined in the main MCA code of practice.

The MCA DoLS are about safeguarding the interests of vulnerable people so as to:

- prevent arbitrary decisions that deprive people who lack capacity of their liberty
- provide people who are deprived of liberty with representatives to advocate on their behalf
- provide people who are deprived of liberty, and their representatives, with rights of appeal against unlawful detention
- ensure that any deprivation of liberty is in a person’s best interests and there are no other options available, or less restrictive options available to them

This procedure describes the responsibilities of Gateshead Council in relation to the process of legally depriving someone who is deemed to lack capacity (known as the ‘Relevant Person’) of their liberty through a legal authorisation.

Only a registered care home or a hospital (known as the Managing Authority) can apply for such authorisation and their application must be to the local authority (known as the ‘Supervisory Body’). The DoL Safeguards cannot be applied to someone being deprived of their liberty within their own home, therefore if information suggests that this is occurring the matter should be dealt with through safeguarding procedures.

It is important to reiterate that these operational procedures should be read in conjunction with the Deprivation of Liberty Safeguards Code of Practice, to supplement the main Mental Capacity Act 2005 Code of Practice. These procedures are not a substitute or a shortcut for the requirements specified in these codes of practice.

Within Gateshead Council the Deprivation of Liberty Safeguards are coordinated by the MCA Coordinator who is situated within the Safeguarding Adults Coordination Team.

4.2 Scope

The DoLS apply to individuals over the age of 18 who lack the capacity to consent but for their own safety and in their best interests need to be accommodated under care or treatment regimes which may deprive them of their liberty within a hospital or care home registered with the Care Quality Commission (CQC). The DoLS do not apply in registered children’s homes, Independent Living Schemes or people’s own homes. Deprivations of liberty in these settings should be addressed through Safeguarding Adults arrangements in the first instance.
DoLS applications should be made to the local authority where the person is ordinarily resident, which has legal responsibility for acting as that person’s Supervisory Body, regardless of whether the person has been placed in a hospital or care home in another area.

4.3 Principles

The Mental Capacity Act’s five key principles apply equally to practice under the deprivation of liberty safeguards.

The MCA Coordinator will work closely with commissioners and providers to provide expertise for strategic planning processes. Every effort should be made by providers and commissioners to deliver care in a way that prevents deprivation of liberty occurring. The code of practice indicates several steps that providers and commissioners can take. These include:

- Following established good practice for care planning
- Ensuring a proper assessment of capacity is carried out in relation to the person being able to accept or decline the care proposed
- Before making any placement, examining whether the person’s needs can be met in a less restrictive manner
- Taking proper steps to help the person retain contact with family and friends, drawing on local advocacy services when needed
- Keeping any restrictions on the person to a minimum and for the shortest period possible
- Ensure the care plan is reviewed on a regular basis, where necessary ensuring an independent element is involved (e.g. advocacy)
- Ensuring that all decisions and rationale are taken in a structured way and recorded appropriately

Only where no less restrictive options are available should a care plan that involves depriving a person of their liberty be considered. In these circumstances, the DoL Safeguards must be applied in a timely manner. A discussion with the MCA Coordinator or duty Safeguarding Adults Coordinator should take place wherever possible prior to an application under the DoLS.

4.4 What is a deprivation of liberty?

There is no legal definition as to what constitutes a Deprivation of Liberty. The judge in the Bournewood case stated that:

‘To determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.’

Each case will need to be assessed on an individual basis. What needs to be considered therefore is whether a care regime is moving or has moved from being within the boundaries of restriction and restraint into a deprivation of liberty.

<table>
<thead>
<tr>
<th>Liberty</th>
<th>Restriction</th>
<th>Deprivation</th>
</tr>
</thead>
</table>

A locked door alone in a residential home is unlikely to amount to deprivation of liberty, nor is encouraging a confused resident to return should they make an attempt to leave. What needs to be considered is the nature of the restriction, its degree, duration and regularity. The code of practice identifies that the following factors may well be relevant in considering when restriction is moving moves into deprivation:

- Staff exercising completed and effective control over the care and movement of a person for a significant amount of time
- The person losing autonomy because they are under continuous supervision and control
- Restraint being used, including sedation, to admit a person to a placement where that person is resisting admission
- A decision being taken by staff that the person will not be released into the care of others, or permitted to live elsewhere unless staff consider it appropriate
- A request by carers/family for a person to be discharged into their care is refused
- The person is unable to maintain social contacts because of the restrictions placed on their access to other people
- Staff exercise control over assessments, treatment, contacts and residence
4.5 Roles and Responsibilities

The Managing Authority

The managing authority is the care home or hospital where it is believed that a person is being deprived of their liberty.

The Managing authority has the responsibility for identifying and applying for an authorisation to deprive someone of their liberty within the scope of the DoL safeguards. The Managing authority in the case of a specific care home will be the person registered, or required to be registered, under part 2 of the Care Standards Act 2000. In the case of a hospital, it will be the NHS trust.

When considering making a DoLS application, it is helpful for the Managing Authority to consider the following procedural stages:

1. How was the person admitted?
2. What are the current arrangements for the person’s care?
3. Does the person have capacity and what consultation has taken place?
4. What type of authorisation is required?

The stages are detailed below:

1. How was the person admitted?
   - Was force or sedative medication used because the person was resisting being admitted? This does not include the use of benign force, such as gently guiding someone by the arm.
   - Was the person deceived to make sure they co-operated? For instance, were they misled into believing that they would return home the next day?
   - Did the person’s relatives, or carers who live with the person, object to them being admitted?

2. What are the current arrangements for the person’s care?
   - Is the person sedated to prevent them leaving? Use of sedatives does not in itself mean that a person is deprived of liberty - it is only relevant if the purpose is to prevent the person from leaving the establishment.
   - Does the person make persistent or purposeful attempts to leave, which are prevented by means of force or a locked door? A locked door does not constitute deprivation on its own, even if its purpose is to prevent residents from wandering. Likewise, for the use of benign force, such as gently guiding someone by the arm to return them when they are wandering. This test is met only if the person’s attempts to leave are persistent and/or purposeful.
   - Is force being used to treat the person when they are resisting other than in an emergency? Use of benign force to administer medication, or to feed or dress someone, does not deprive someone of liberty. Emergencies could include disturbed, threatening or self harming behaviour.
   - Have any relatives or carers asked for the person to be discharged to their care, and has this request been refused?
   - Have any relatives or carers been refused access to the person, or had severe restrictions put on their access? Reasonable restrictions of visiting hours etc are not relevant.
   - Has the person been prevented from spending time with any of the people who matter to them? This would, for instance, include preventing the person from spending free time with friends inside or outside the home. It would not include guiding the person away from casual acquaintances who appear to be abusing or exploiting the person, or reasonable restrictions on the times when the person can socialise with friends, for instance because of the pattern of the establishment’s daily routine.
   - Is the way the person’s care is organised, severely restrictive in what they can do in other ways? An example of a severe restriction could be placing the person for a large proportion of their waking time in a position that prevents them from moving (e.g. using furniture which they cannot get up from). It would not be a severe restriction to use furniture designed to keep the person safe, which they cannot get up from unaided, if they are usually able to get help to get out of it when they show a persistent or purposeful desire to do so.
   - Has the person’s access to the community been severely restricted because of concerns about public sector safety? It is not deprivation of liberty to require someone to be escorted on trips out of the care home, if this is in the interests of their own safety rather than that of others, even if this means that the person is sometimes temporarily not permitted to leave.
3. Does the person have capacity and what consultation has taken place?

- Does the person have the Capacity to make their own decision about whether to be accommodated in this care home for the purpose of being given the proposed care or treatment?

- Has it been established through wider consultation (other professionals, family, friends, carers) that accommodating them in this care home is the least restrictive option and in their best interests (and have you got the appropriate paper work completed to evidence this?)?

- Is the person able to:
  - Understand the information?
  - Retain the information?
  - Weigh up the information?
  - Communicate their decision?

Remember that ultimately it is the responsibility of the Managing Authority to make the decision as to whether there is sufficient indication that the person concerned is being deprived of their liberty, and therefore whether a request for authorisation should be made.

4. What type of authorisation is required?

An Urgent Authorisation must be completed if:

- the person lacks capacity, is resident in the care home or hospital, and the Managing Authority believes that they are already being deprived of their liberty.

The Managing Authority must then complete Form 1 - Urgent Authorisation, along with Form 4 – Request for Standard. N.B. Legally, Form 1 cannot be submitted without Form 4.

A request for Standard Authorisation must be completed if:

- the person lacks capacity and is not yet resident in the hospital or care home, but is expected to be admitted within the next 21 days, and is expected to be deprived of their liberty

- the person is already resident in the care home or hospital and is not yet being deprived of their liberty, but the care arrangements are expected to change within the next 21 days and as a result the person will be deprived of their liberty.

The Managing Authority must then complete Form 4 – Request for Standard only.

The detailed DoLS administrative process is described within the appendix.

The Supervisory Body

The Supervisory Body is a specific function in connection with the Deprivation of Liberty Safeguards vested as a responsibility within Gateshead Metropolitan Borough Council and manifested through the undertaking of the DoLS “Signatory” role by senior officers who scrutinise and if appropriate authorise under the DoLS.

The Supervisory Body is responsible for overseeing the workings of the Deprivation of Liberty Safeguards to protect adults ordinarily resident within Gateshead. In conjunction with Gateshead’s Safeguarding Adults from Abuse Multi-Agency Policy and Procedures, the Supervisory Body must ensure that any such deprivation of liberty is lawful and applied in the least restrictive manner for the minimum period of time.

The Supervisory Body and its constituent members are responsible for scrutinising and authorising each individual standard application and ensuring the supporting assessments are completed to the required standard. In most cases the choice of signatory will not be an issue. However in certain cases there may be a conflict of interests at Service manager level because of supervisory responsibilities:

- Service managers who have responsibility for a care home run by the Council will NOT be able to act as signatory in any case involving a resident of that care home as they will have management responsibility for the Managing Authority making the application.

- Service managers with significant prior involvement with a case or supervisory responsibility for the allocated worker involved will NOT be able to act as signatory in any case involving that person.

The Director of Adult Social Services has overall responsibility for the Council’s Supervisory Body functions, and is accountable to the Care Quality Commission, the statutory monitor of the operation of the DoLS.

The Supervisory Body shall be responsible for ensuring that there are sufficient numbers of trained and experienced Best Interest Assessors available at any one time to perform their duties effectively.

The Best Interests Assessor (BIA)

The Best Interests Assessment is often the most important assessment within the DoLS process, as it requires the BIA to establish whether a DoL is occurring or is likely to occur and to determine if it is in the person’s best interests.
The BIA is responsible and accountable for their independent practice and judgments. As a matter of law the decision of best interests is one made autonomously by the BIA and they are responsible for it. Managers must respect this and will not seek to influence the BIA’s actions.

The BIA is also responsible for undertaking the DoLS Age Assessment, No Refusals Assessment and for identifying someone to act as the Relevant Person’s Representative (RPR). In recommending the RPR, BIA should not automatically disregard relatives who are opposed to the DoL. In addition, if safeguarding concerns have been raised in relation to a family member this again should not automatically bar them from the role of RPR: the regulations do not refer to barring someone on this basis. Advice must be sought in these situations from the MCA Coordinator.

BIAs employed by Gateshead Council cannot assess someone if they are in a care home operated by Gateshead Council, as there would be no independent scrutiny given that Gateshead Council would be both the Managing Authority and Supervisory Body. In these circumstances, the MCA Coordinator will source a BIA from a neighbouring Local Authority, or commission an Independent BIA.

The role of the Best Interests Assessor (BIA) is comprehensively described in Chapter 4 of the DoLS Code of Practice.

The Mental Health Assessor

The Mental Health Assessor undertakes the Capacity Assessment, Eligibility Assessment and Mental Health Assessment. Within the Mental Health Assessment, the assessor is required to consider how the mental health of the person being assessed is likely to be affected by being deprived of their liberty, and to report their conclusions to the BIA.

The Mental Health Assessor is a doctor who is either approved under Section 12 of the Mental Health Act 1983, or a registered medical practitioner with at least three years’ post-registration experience in the diagnosis or treatment of mental disorder, such as a GP with a special interest. To be eligible to undertake assessments in England, a doctor will need to have completed the standard training for deprivation of liberty mental health assessors. Except in the 12 month period beginning with the date the doctor has successfully completed the standard training, the regulations for England also require the supervisory body to be satisfied that the doctor has, in the 12 months prior to selection, completed further training relevant to their role as a mental health assessor.

The IMCA

The IMCA’s role is to support the relevant person and their unpaid representative. This may be to help them to better understand process and effects of the DoLS authorisation, and may also be if they need help to use the review system or to access the court of protection.

As part of its Supervisory Body responsibilities, Gateshead Council must appoint an IMCA as soon as it has been identified that the person subject to the request for authorisation under the DoLS is unrepresented.

Once a DoLS Authorisation has been granted, the relevant person (the person subject to the DoL) and their unpaid representative have a statutory right to access an IMCA and the Supervisory Body should make them aware of this.

The MCA Coordinator will automatically appoint an IMCA to support anyone acting as an RPR for the first time, and to support an RPR when there are conditions attached to a DoLS authorisation.

Gateshead’s commissioned IMCA provider is Your Voice Counts.

The Relevant Person’s Representative (RPR)

The role of the Relevant Person’s Representative is to maintain contact with the relevant person and to support them in all aspects relating to the DoLS. Once an authorisation has been granted a Relevant Person’s Representative will be appointed, based on the BIA’s recommendation.

The BIA will be able, in most cases, to recommend somebody to be the relevant person’s representative (i.e. a family member or friend). If the BIA is unable to recommend anyone, the supervisory body must appoint someone to perform this role in a professional capacity. This is known as a paid RPR.

Gateshead has commissioned its IMCA provider, Your Voice Counts to undertake this role.

Chapter 7 of the DoLS code of practice explains more fully the role of the Relevant Person’s Representative.
Overview of Deprivation of Liberty Safeguards (DoLS) Process

A hospital or care home identifies that an incapacitated person over 18 is deprived, or is at risk of being deprived of their liberty and request DoLS authorisation

Application received and scrutinised by MCA Coordinator who commissions the 6 qualifying assessments, instructs an IMCA for anyone without representation, and provides support to all involved in the DoLS process

Assessments undertaken by a Mental Health Assessor (MHA)
- Eligibility Assessment
- Mental Health Assessment
- Mental Capacity Assessment

Assessments undertaken by a Best Interests Assessor (BIA)
- Best Interests Assessment
- Age Assessment
- No Refusals Assessment

Are all Assessments met?

Yes

The MCA Coordinator presents case to DoLS signatory who scrutinises the assessments, makes any care management recommendations and formally declares the deprivation of liberty NOT authorised

The BIA recommends the period of authorisation (up to 12 months), identifies a suitable person to act as the relevant person's representative, and may recommend conditions be attached to the authorisation to

No

The MCA Coordinator presents case to DoLS signatory who may shorten the period of authorisation or change the conditions recommended by the BIA. The signatory formally authorises the deprivation of liberty and any conditions are now legally binding.

A relevant person's representative is appointed by the supervisory body to support the individual during the DoLS authorisation.

The hospital, care home, person deprived or their representative requests a review due to a change in circumstances

A review is carried out. Are all of the qualifying assessments still met?

Yes

DoLS authorisation continues

No

The person subject to DoLS leaves the hospital or care home or is detained under the Mental Health Act 1983 for more than 28 days

The MCA Coordinator formally ends the DoLS authorisation

STAGE 1

STAGE 2

STAGE 3

STAGE 4

STAGE 5
4.6 The DoLS Process

The DoLS process is administratively complex, and can be very difficult to negotiate for those unfamiliar with it, however, the MCA Coordinator and Safeguarding Adults Coördination Team will provide support throughout all DoLS processes and access advice from Legal Services should this be indicated.

The DoLS process incorporates 5 clear stages:

1. Receiving an application
2. The qualifying assessments
3. Authorisation granted or not granted
4. Review
5. End

The flow chart on the next page provides a basic overview of the DoLS process.

1. Receiving an application

On receiving an enquiry from either a Managing Authority or a member of the public concerning a possible Deprivation of Liberty, the MCA Coordinator, possible, will initially try to establish as much understanding as possible about the nature of the situation, the level of restriction or deprivation and the level of behaviour, understanding or capacity of the individual affected.

From the date of receipt of the Request for Authorisation the Supervisory Body has 21 calendar days (7 if the Managing Authority have issued themselves with an Urgent Authorisation) to commission and complete all 6 assessments and to respond to the Managing Authority.

The MCA Coordinator will commission the 6 qualifying assessments and keep in contact with the Managing Authority and assessors throughout in order to provide advice and respond to any arising issues. If necessary, the MCA Coordinator will instruct an IMCA for the BIA to consult with over the person’s best interests.

2. The Qualifying Assessments

The six assessments needed in order to satisfy the requirements of DoLS authorisation are:

- Age assessment
- No refusals assessment
- Best interests assessment
- Mental capacity assessment
- Mental health assessment
- Eligibility assessment

The assessments must be completed within 21 days for a standard authorisation or, where an urgent authorisation has been given, before that authorisation expires (usually 7 days). There must be a minimum of two assessors – the Mental Health and Best Interests Assessors must be different people. It is Gateshead’s policy to commission the age, no refusals and best interests assessments from a Best Interests Assessor (BIA), and the mental capacity, mental health and eligibility assessments from a Mental Health Assessor.

The age assessment confirms whether the relevant person is 18 or over.

The no refusals assessment establishes whether an authorisation would conflict with any other existing authority for decision-making for that person, such as an advance decision to refuse treatment under the Mental Capacity Act 2005.

The best interests assessment establishes whether deprivation of liberty is occurring or is going to occur, and if so, whether it is:

- In the best interests of the relevant individual to be deprived of their liberty
- Necessary for them to be deprived of liberty in order to prevent harm to themselves
- A proportionate response to the likelihood of suffering harm and the seriousness of that harm.

The mental capacity assessment establishes whether the relevant individual lacks capacity to decide whether or not they should be accommodated in the relevant hospital or care home to be given care.

The mental health assessment determines whether the relevant individual has a mental disorder within the meaning of the Mental Health Act 1983. This is not an assessment to determine whether the person requires mental health treatment.

The eligibility assessment relates specifically to the relevant individual’s status, or potential status, under the Mental Health Act 1983. An individual is eligible unless they are:

- Detained in hospital under Section 2, 3, 4, 5(2), 5(4) or under the an order of Part III of the Mental Health Act 1983
  or
- Subject to, under the Mental Health Act 1983, a Section 7 Guardianship Order, Section 17 Leave or Section 17A Community Treatment Order, which requires them to live somewhere other than where the DoLS authorisation has been requested.
The proposed authorisation relates to a deprivation of liberty in a hospital for the purpose of treatment of a mental disorder and

- The person objects to being admitted to hospital, or to some or all the treatment, and
- The person meets the criteria for an application for compulsory admission under a relevant section of the Mental Health Act 1983.

### 3 Authorisation granted or not granted

The MCA Coordinator will meet with the signatory and present the DoLS file containing any Urgent Authorisations, Requests for Standard Authorisations, completed qualifying assessments and any other relevant documents such as Court orders. The MCA Coordinator will highlight any significant concerns or legal issues.

The regulations require the signatory to grant the application if all 6 qualifying assessments are positive. However, case law indicates that it is the Supervisory Body’s responsibility to **ensure all assessments are properly completed**. If they are not then the DoLS cannot be authorised. For example, the signatory may find that the BIA has not consulted all the interested parties and so the validity of the BIA’s conclusion as to what is in the person’s best interests must be called to question.

If the authorisation is to be granted the signatory completes **Form 12**. The Best Interests Assessment will have recommended a period of authorisation which cannot exceed 12 months. The signatory may choose to shorten this period, but cannot extend it. The BIA may have recommended conditions to be attached to the DoLS authorisation in order to reduce the effect of the deprivation of liberty, or to bring it to a swifter conclusion. The signatory is not obliged to accept these conditions and can strike them, amend them, or add in their own.

If a DoLS authorisation is being put in place to restrict or prevent access by a family member or acquaintance then this will have impact on the Article 8 Human Rights of both the person deprived of their liberty and the family member. Conditions should be considered that will guide the Managing Authority on how to manage the situation and maintain the relationship.

When a person is subject to DoLS authorisation which includes conditions, the case must remain allocated to a Social Worker (not an Assessing Officer) for the duration of the authorisation so that the conditions can be appropriately monitored. In such cases an IMCA will be appointed to support the RPR.

If any of the qualifying assessments have failed, and the authorisation is not to be granted, the signatory completes **Form 13**.

The signatory completes **form 25** to appoint a suitable RPR.

The MCA Coordinator ensures that copies of all standard forms are circulated, and that any authorisation under the DoLS has appropriate monitoring arrangements in place.

### 4. Review

DoLS authorisations should never be allowed to “lapse”. If it is believed that the authorisation is no longer necessary because one or more of the 6 qualifying assessments is no longer met, a review must be requested. This request could originate from:

- The person subject to the authorisation
- The RPR
- The IMCA
- The Managing Authority
- The Supervisory Body

The MCA Coordinator will decide whether the request for review is appropriate, and if so, which elements need to be reviewed. A review assessment will need to be carried out for each element where there has been a change of circumstance. The MCA Coordinator will inform the person subject to authorisation, their RPR, the Managing Authority and any IMCA involved that a review is to be carried out.

The review process will follow the same lines as the original DoLS assessment process. If any of the requirements cease to be met, the DoLS authorisation will be terminated with immediate effect. Once an Authorisation comes to an end the Managing Authority cannot lawfully continue to deprive the relevant person of their liberty.

**Form 22** is used to summarise the outcome of the review and should be authorised by a signatory from the Supervisory Body. **Form 22** and copies of any assessments carried out during the review should be sent to all of those involved.
5. Ending DoLS authorisation

DoLS authorisations only allow the person to be deprived of their liberty in the hospital or care home stated, for the period of time stated. They cannot transfer to another setting and their duration cannot be extended.

If a person leaves the environment where the authorisation has been given permanently, or for a substantial period of time, the MCA Coordinator must be informed so that the authorisation can be brought to an end. DoLS authorisations are formally terminated by the completion and circulation of Form 23. Consideration should be given as to whether the person is being deprived of their liberty in their new setting, and if so, that establishment must make a new application for authorisation.

If an existing DoLS authorisation is about to come to an end and the Managing Authority feels the person still needs to be deprived of their liberty in their best interests, then it must apply for a further Standard Authorisation. Once requested, the process for a further DoLS application is the same as that for obtaining the original authorisation.

If any of the qualifying assessments used in the existing authorisation are less than twelve months old and still valid, they may be used. It is not good practice to use an existing Best Interests Assessment.

If a person subject to authorisation under the DoLS is subsequently detained in hospital under the Mental Health Act 1983, the MCA Coordinator must be informed so that the DoLS authorisation can be suspended. The suspension will last for up to 28 days. If the person returns within 28 days, the suspension will be lifted and the DoLS authorisation will resume. If the person’s detention in hospital under the Mental Health Act 1983 continues for more than 28 days, then the MCA Coordinator will terminate the Standard Authorisation.

4.7 Unauthorised Deprivations of Liberty

It is a serious issue to deprive someone of their liberty without authorisation and if anyone feels this is occurring they should take action immediately.

Initially anyone believing that a person is being deprived of their liberty without authorisation they should discuss this with the Managing Authority. The Managing Authority should respond within 24 hours. If the Managing Authority does not resolve the situation or apply for an authorisation then the concerned person can ask the Supervisory Body (via the MCA Coordinator) to decide.

The Supervisory Body does not have to investigate this further if:

- the request appears to be vexatious or frivolous.
- Where a recent assessment has been carried out and repeat requests are received.
- Where there is no change of circumstance that would merit the question being considered again.

If the request appears genuine the Supervisory Body should appoint someone eligible to be a Best Interests Assessor to consider if the relevant person is deprived of their liberty. They will notify all concerned using form 16:

- That they have been asked to assess whether a DoL is taking place.
- Whether or not they have decided to commission an assessment.
- Who the relevant assessor is.

The Supervisory Body will use Form 17 to record their decision and forward this to the person who raised the concern, the relevant person, the Managing Authority and any IMCA involved. If the BIA’s assessment indicates a DoL is taking place then they will start the process as if the Managing Authority had applied for a Standard Authorisation.

The MCA Coordinator will inform the CQC and consider whether a Safeguarding Adults alert needs to be made.

Chapter 9 of the DoLS code of practice explains this in more detail.
Appendix 1

There are 32 standard DoLS forms, each with a different function. The table below describes what each form is for, and who is responsible for its completion.

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<tr>
<th>Form</th>
<th>Description</th>
<th>Completed by</th>
</tr>
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<tbody>
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<td>Urgent authorisations</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Urgent authorisation granted by a managing authority</td>
<td>Care Home/hospital</td>
</tr>
<tr>
<td>2</td>
<td>Managing authority request for an extension in the duration of an urgent authorisation</td>
<td>Care Home/hospital</td>
</tr>
<tr>
<td>3</td>
<td>Supervisory body’s decision regarding a request for an extension of an urgent authorisation</td>
<td>MCA Coordinator</td>
</tr>
<tr>
<td>Requests for a standard authorisation</td>
<td></td>
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<td>4</td>
<td>Managing authority request for a standard authorisation</td>
<td>Care Home/hospital</td>
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<tr>
<td>Requests for a standard authorisation - Assessment forms</td>
<td></td>
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<tr>
<td>5</td>
<td>Age assessment form</td>
<td>BIA</td>
</tr>
<tr>
<td>6</td>
<td>Mental health assessment form for completion by assessor</td>
<td>Mental Health Assessor</td>
</tr>
<tr>
<td>7</td>
<td>Mental capacity assessment form</td>
<td>Mental Health Assessor</td>
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<td>8</td>
<td>No refusals assessment form</td>
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<tr>
<td>9</td>
<td>Eligibility assessment form</td>
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<td>10</td>
<td>Best interests assessment</td>
<td>BIA</td>
</tr>
<tr>
<td>11</td>
<td>Record by supervisory body that an equivalent assessment is being used</td>
<td>MCA Coordinator</td>
</tr>
<tr>
<td>Requests for a standard authorisation - Recording the outcome of the request</td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Supervisory body gives a standard authorisation</td>
<td>Signatory</td>
</tr>
<tr>
<td>13</td>
<td>Supervisory body declines a request for a standard authorisation</td>
<td>Signatory</td>
</tr>
<tr>
<td>Suspension of standard authorisations</td>
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<tr>
<td>14</td>
<td>Managing authority notifies the supervisory body that a standard authorisation should be suspended because the person has been detained under the Mental Health Act 1983</td>
<td>Care Home/ Hospital</td>
</tr>
<tr>
<td>15</td>
<td>Supervisory body notifies all involved that the suspension of the standard authorisation is lifted because the person has ceased to be detained under the Mental Health Act 1983 within 28 days</td>
<td>MCA Coordinator</td>
</tr>
</tbody>
</table>
### Form | Description | Completed by
---|---|---
**Unauthorised deprivation of liberty**
16 | Record of supervisory body action on receipt of notification of a possible unauthorised deprivation of liberty | MCA Coordinator
17 | Unauthorised deprivation of liberty assessor’s report | BIA
18 | Supervisory body’s decision following the receipt of an unauthorised deprivation of liberty assessor’s report | Signatory

**Review of a standard authorisation**
19 | Managing Authority requesting review of the existing standard authorisation by the supervisory body | Care Home/hospital
20 | Supervisory body notifies relevant interested parties that a review is to be carried out. | MCA Coordinator
21 | Supervisory body records its decision as to whether any qualifying requirements are reviewable | MCA Coordinator
22 | Supervisory body’s decision following receipt of review assessments | Signatory

**Standard authorisation ceased to be in force**
23 | Supervisory body gives notice that a standard authorisation has ceased to be in force | MCA Coordinator

**Relevant person’s representative**
24 | Selection of a relevant person’s representative | BIA
25 | Supervisory body appointment of a relevant person’s representative | Signatory/ MCA Coordinator
26 | Supervisory body gives a relevant person’s representative notice of the pending termination of their appointment | MCA Coordinator
27 | Supervisory body terminates a relevant person’s representative’s appointment | MCA Coordinator

**Mental health assessor and best interests assessor referral forms**
28 | Best interests assessor referral form | MCA Coordinator
29 | Mental health assessor referral form | MCA Coordinator

**IMCA referral and report forms**
30 | IMCA referral form | MCA Coordinator
31 | IMCA report form | IMCA

**Record of deprivation of liberty safeguards activity**
32 | Record of assessments, authorisations and reviews | MCA Coordinator

The standard forms are available from the MCA Coordinator or the Safeguarding Adults Coordination Team. The forms are regularly reviewed and updated, so it is recommended that managing authorities, BIAs and MHAs source their forms directly from the MCA Coordinator every time, to ensure that they are current.
Appendix 2

The table below describes the DoLS Administrative process, who is responsible for each stage, and which standard forms should be completed.

<table>
<thead>
<tr>
<th>Task</th>
<th>Completed by</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete Form 1, granting an Urgent Authorisation which will give the legal authority for depriving the person of their liberty for 7 days whilst the Supervisory Body undertakes the assessments for a Standard Authorisation.</td>
<td>Managing Authority</td>
<td>As soon as there is evidence a deprivation is occurring</td>
</tr>
<tr>
<td>2. Complete Form 4, requesting a Standard Authorisation from the Supervisory Body.</td>
<td>Managing Authority</td>
<td>At the same time as Form 1</td>
</tr>
<tr>
<td>3. Email, fax or hand deliver both forms to the MCA Coordinator. It is not acceptable to post DoLS applications due to the tight timescales.</td>
<td>Managing Authority</td>
<td>Within 24 hours</td>
</tr>
</tbody>
</table>

**Go to step 6**

The person is not yet being deprived of their liberty within the care home or hospital, but the Managing Authority believes that they will be within the next 21 days. OR The person is currently subject to a Standard DoLS authorisation which is due to end within the next 28 days, and the Managing Authority believes that deprivation of liberty is likely to continue.

<table>
<thead>
<tr>
<th>Task</th>
<th>Completed by</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Complete Form 4, requesting a Standard Authorisation from the Supervisory Body.</td>
<td>Managing Authority</td>
<td>Up to 21 days in advance of the date authorisation is needed.</td>
</tr>
<tr>
<td>5. Email, fax or hand deliver both forms to the MCA Coordinator. It is not acceptable to post DoLS applications due to the tight timescales.</td>
<td>Managing Authority</td>
<td>As soon as completed.</td>
</tr>
<tr>
<td>6. Scrutinise the forms and contact Managing Authority to discuss/agree any amendments needed.</td>
<td>MCA Coordinator</td>
<td>The same day the application is received.</td>
</tr>
<tr>
<td>7. Create file for documentation. Create unique identification number Enter details of application onto Department of Health spreadsheet</td>
<td>MCA Coordinator</td>
<td>The same day the application is received.</td>
</tr>
<tr>
<td>8. If box B10A on Form 4 is ticked, complete Form 30 to instruct a 39A IMCA. Email to IMCA provider with copies of any forms.</td>
<td>MCA Coordinator</td>
<td>The same day the application is received.</td>
</tr>
<tr>
<td>9. Commission a Mental Health Assessor to undertake the Mental Capacity, Eligibility and Mental Health Assessments. Email the assessor a copy of the application and Forms 6, 7 and 9 for them to complete.</td>
<td>MCA Coordinator</td>
<td>The same day the application is received.</td>
</tr>
<tr>
<td>Task</td>
<td>Completed by</td>
<td>Timescale</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>10 Allocate the Best Interests, Age and No refusals assessments</td>
<td>MCA Coordinator</td>
<td>The same day the application is received</td>
</tr>
<tr>
<td>to the BIA on duty. If the application is from a care home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>operated by Gateshead Council, a Gateshead Council BIA cannot be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>used and instead a BIA must be sourced from a neighbouring authority,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or an independent BIA commissioned.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email the BIA a copy of the application and <strong>Forms 8, 10 and 24</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Check availability of DoLS signatories and book a signatory</td>
<td>MCA Coordinator</td>
<td>The same day the application is received</td>
</tr>
<tr>
<td>meeting to take place 1 day before the authorisation is needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 The 6 qualifying assessments are undertaken and submitted to the</td>
<td>Mental Health Assessor and Best</td>
<td>2 hours before the signatory meeting at the</td>
</tr>
<tr>
<td>MCA Coordinator.</td>
<td>Interests Assessor</td>
<td>very latest.</td>
</tr>
</tbody>
</table>

**If any of the qualifying assessments fail, authorisation under the DoLS cannot be given.**

<table>
<thead>
<tr>
<th>Task</th>
<th>Completed by</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Prepare <strong>Form 13</strong> and paper file for signatory meeting. File</td>
<td>MCA Coordinator</td>
<td>In advance of signatory meeting</td>
</tr>
<tr>
<td>must contain all completed assessments and any other relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>documents the signatory may need (e.g. court orders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Attend signatory meeting. MCA coordinator should brief the</td>
<td>Signatory/MCA Coordinator</td>
<td>During signatory meeting</td>
</tr>
<tr>
<td>signatory about any pertinent legal or care management issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory will scrutinise the assessments and may make care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>management recommendations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory will sign <strong>Form 13</strong> to formally evidence that</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DoLS Authorisation has NOT been given.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Go to step 19**

**If all of the qualifying assessments are met, authorisation under the DoLS must be given, unless the signatory feels that any of the assessments are substandard.**

<table>
<thead>
<tr>
<th>Task</th>
<th>Completed by</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Prepare <strong>Forms 12 and 25</strong> and paper file for signatory meeting.</td>
<td>MCA Coordinator</td>
<td>In advance of signatory meeting</td>
</tr>
<tr>
<td>File must contain all completed assessments and any other relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>documents the signatory may need (e.g. court orders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 If the BIA has not been able to identify a suitable person to act</td>
<td>MCA Coordinator</td>
<td>In advance of signatory meeting</td>
</tr>
<tr>
<td>as RPR, contact Your Voice Counts to request a paid RPR. <strong>Form 25</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>must name the individual advocate who will undertake this role.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Attend signatory meeting. MCA coordinator should brief the</td>
<td>Signatory/MCA Coordinator</td>
<td>During signatory meeting</td>
</tr>
<tr>
<td>signatory about any pertinent legal or care management issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory will scrutinise the assessments and may shorten the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>period of authorisation recommended by the BIA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory may amend or delete the conditions recommended by the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIA, and may add in conditions of their own.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory will sign <strong>Form 12</strong> to formally give DoLS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorisation, and <strong>Form 25</strong> to appoint the RPR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The signatory may make care management recommendations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Make any amendments to <strong>Form 12</strong> as per signatory’s instructions.</td>
<td>MCA Coordinator</td>
<td>Same working day as signatory meeting</td>
</tr>
<tr>
<td>19 If appropriate, complete <strong>Form 30</strong> to instruct a 39D IMCA to</td>
<td>MCA Coordinator</td>
<td>Same working day as signatory meeting</td>
</tr>
<tr>
<td>support the person, the RPR, or both. Email to Your Voice Counts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Completed by</td>
<td>Timescale</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>20 Record outcome on Care First. Relay outcome and any care management</td>
<td>MCA Coordinator</td>
<td>Same working day as signatory</td>
</tr>
<tr>
<td>instructions/recommendations to the Managing Authority and allocated</td>
<td></td>
<td>meeting</td>
</tr>
<tr>
<td>Social Worker/Assessing Officer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Inform the CQC of the outcome of the DoLS application using the</td>
<td>Managing Authority</td>
<td></td>
</tr>
<tr>
<td>Statutory Notification.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Prepare and circulate Standard letters informing all relevant</td>
<td>MCA Coordinator</td>
<td>Within 2 working days of signatory meeting</td>
</tr>
<tr>
<td>parties of the outcome of the DOLS process. Everyone involved in the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>incapacitated person, is entitled to copies of every form. Ensure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that all signed DoLS forms are scanned and uploaded to CIVCA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 For cases where DoLS authorisation has been given, set up</td>
<td>MCA Coordinator</td>
<td>Within 2 working days of signatory meeting</td>
</tr>
<tr>
<td>monitoring activity on Care First to prompt 4 weeks before end of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>authorisation period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Update Department of Health spreadsheet.</td>
<td>MCA Coordinator</td>
<td>Within 2 working days of signatory meeting</td>
</tr>
<tr>
<td>25 Contact the managing authority to remind them that the DoLS</td>
<td>MCA Coordinator</td>
<td>When prompted by DoLS Care First desktop</td>
</tr>
<tr>
<td>authorisation will end in 28 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 If MA believes DoLS authorisation will need to continue beyond</td>
<td>Managing Authority</td>
<td>21 days before end of existing</td>
</tr>
<tr>
<td>the existing authorisation, they will need to request another</td>
<td></td>
<td>authorisation</td>
</tr>
<tr>
<td>Standard authorisation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Go to step 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 If the managing authority believes DoLS authorisation is no longer</td>
<td>Managing Authority</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>needed, they must complete and submit form 19.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A review of an existing DoLS authorisation has been requested.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Letter 3 or equivalent received or Form 19 received or Supervisory</td>
<td>RPR/IMCA/Managing Authority/</td>
<td>At any time during the period of</td>
</tr>
<tr>
<td>Body decides to review</td>
<td>Supervisory Body</td>
<td>authorisation</td>
</tr>
<tr>
<td>29 Complete form 21 to determine if review is to be carried out</td>
<td>MCA Coordinator</td>
<td>The same working day</td>
</tr>
<tr>
<td>30 If no grounds for review identified. Prepare circulation list,</td>
<td>MCA Coordinator</td>
<td>The same working day</td>
</tr>
<tr>
<td>circulate Standard letters and copies of Form 21 and store circulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>list on file. Record outcome in Care First Observation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 If grounds for review are identified complete Form 21. Prepare</td>
<td>MCA Coordinator</td>
<td>The same working day</td>
</tr>
<tr>
<td>circulation list, circulate Standard letters and copies of Forms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 and 21 and store circulation list on file.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Check availability of DoLS signatories and book a signatory</td>
<td>MCA Coordinator</td>
<td>Within 14 days of request for review</td>
</tr>
<tr>
<td>meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 If 1 or more of capacity, eligibility or mental health assessments</td>
<td>MCA Coordinator</td>
<td>Within 24 hours of request for review</td>
</tr>
<tr>
<td>is to be reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commission a Mental Health Assessor to undertake the relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Completd by</td>
<td>Timescale</td>
</tr>
<tr>
<td>------</td>
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<td>-----------</td>
</tr>
</tbody>
</table>
| **34** If 1 or more of age, no refusals or best interests assessments is reviewable.  
   Allocate the BIA on duty to undertake the relevant review.  
   If the review involves a care home operated by Gateshead Council, a Gateshead Council BIA cannot be used and instead a BIA must be sourced from a neighbouring authority, or an independent BIA commissioned. | MCA Coordinator | Within 24 hours of request for review |
| **35** Complete Form 22 to determine if authorisation continues/conditions are varied | MCA Coordinator | As soon as reviewed assessments are returned |

**If 1 or more reviewed assessments fail. Authorisation must be ended.**

<table>
<thead>
<tr>
<th>Task</th>
<th>Completd by</th>
<th>Timescale</th>
</tr>
</thead>
</table>
| **36** Prepare Forms 23, 26, 27 and paper file for signatory meeting.  
   Attend signatory meeting. MCA coordinator should brief the signatory about any pertinent legal or care management issues.  
   The signatory will scrutinise the reviewed assessments and may make care management recommendations.  
   The signatory will sign Form 23, 26 and 27 to terminate the DoLS authorisation and the appointment of the RPR. | MCA Coordinator | In advance of signatory meeting  
   MCA Coordinator | During signatory meeting |

**Go to step 19**

**If the reviewed assessments evidence all qualifying requirements are still met - authorisation must continue.**

<table>
<thead>
<tr>
<th>Task</th>
<th>Completd by</th>
<th>Timescale</th>
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</thead>
</table>
| **37** If another period of authorisation is indicated Prepare forms 11, 12, 25.  
   Attend signatory meeting. MCA coordinator should brief the signatory about any pertinent legal or care management issues.  
   The signatory will scrutinise the reviewed assessments and may shorten the period of authorisation recommended by the BIA.  
   The signatory may vary the existing conditions or amend or delete the conditions recommended by the BIA, and may add in conditions of their own.  
   The signatory will sign Form 12 to formally give DoLS Authorisation, and Form 25 to appoint the RPR.  
   The signatory may make care management recommendations. | MCA Coordinator | In advance of signatory meeting  
   MCA Coordinator/Signatory | During signatory meeting |

**Go to step 17**
Listed below are some of the key Gateshead contacts.

**Care Quality Commission**
Mon - Fri 8.30am-5:30pm
Telephone: 03000 616161

**Gateshead Clinical Commissioning Group**
tel: 0191 497 1494
email: gatesheadccg@sotw.nhs.uk

**Gateshead Council, Adult Social Care Direct**
For any concerns relating to the welfare of adults in Gateshead
24 hours, 7 days per week
Tel: (0191) 433 7033
email: adultsocialcaredirect@gateshead.gov.uk

**Gateshead Council, Mental Capacity Act Coordinator**
For any issues relating to MCA or to request DoLS authorisation
Mon - Thurs 9am-5pm, Friday 9am-4.30pm
Tel: (0191) 433 2362
Email: dolsgateshead@gateshead.gov.uk

**Gateshead Council, Referral and Assessment**
For any concerns relating to the welfare of children in Gateshead
24 hours
Tel: (0191) 433 2653

**Health Watch - Consumer champion for health and social care**
General enquiries 0191 491 1668
Information & signposting - Freephone 0808 801 0382
email: info@healthwatchgateshead.co.uk

**Newcastle Hospitals NHS Foundation Trust**
Mental Capacity Act/Deprivation of Liberty Lead Safeguarding Team
Tel: (0191) 28 29336

**Northumbria Police**
24 hours
Tel: 03456 043 043 ext 69191 or ‘999’ in an emergency

**Northumberland, Tyne and Wear NHS Foundation Trust**
Mental Health Legislation Development Lead
Tel: (0191) 566 7084

**Queen Elizabeth Hospital**
Safeguarding Adults/Mental Health Act Lead Nurse
Tel: (0191) 445 6341
If you would like any more information or to discuss this document, please contact the Safeguarding Adults Co-ordination Team on 0191 433 3361.

If you would like this information in a different format such as large print, Braille, on audio cassette/CD/MP3 or in a different language, please call 0191 433 3361.