London Region MCA /DoLS Tools and Resource Pack

The purpose of this pack:
To provide a range of tools and resources to support health organisations to implement and monitor the application of the Mental Capacity Act.

How to use this pack: The content of this pack can be utilised by MCA Leads and all healthcare staff. The headings for each page are colour coded to assist in navigation of pages.

MCA Leads

Healthcare Staff/MCA Leads

Version 1 (26th January 2024)
Review date: 28th March 2024

Any Questions contact elaine.ruddy@nhs.net

Contents

Glossary

Term / Abbreviation	What it stands for
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act (2005)
MC(A)A	Mental Capacity (Amendment) Act (2019)
ACP	Advance Care Planning
ADASS	Association of Directors of Adult Social Services
ADCS	Association of Directors of Children's Services
ADRT	Advanced Decision to Refuse Treatment
AMCA	Approved Mental Capacity Professional
LA	Local Authority
CHC	Continuing Healthcare
BIA	Best Interest Assessor
ICB	Integrated Care Board
CoP	Court of Protection
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
ECHR	European Convention of Human Rights
HEE	Health Education England
HRA	Human Rights Act (1998)
ICS	Integrated Care Systems
IMCA	Independent Mental Capacity Advocates
LPA (Health and Welfare)	Lasting Power of Attorney
MHA	Mental Health Act (1983, amended 2007)
NHS	National Health Service
CYP	Children and Young People
YP	Young Person refers to a 16–17-year-old
SG	Safeguarding

Background and Context

The London Region MCA & DoLS Working Group aims to support the NHS working with social care in developing a series of guidance's/protocols and processes to promote embedding MCA Practice Oversight and Quality of MCA application across all specialisms and work programmes. The group assists in identifying priority areas and actions organisations can pursue at a local level, to improve implementation of the Mental Capacity Act and DoLS.

Significant work and scoping had been undertaken in London in preparation for Liberty Protection Safeguards and three key priority areas were identified for the region.

- Embedding MCA Practice Oversight and Quality of MCA application across all specialisms and work programmes.
- Ensuring that Community DoLS Applications are being made for any individuals in receipt of Continuing Healthcare funded care in own homes or tenancy-based accommodation (for example, supported living), that meet the criteria of a deprivation of liberty.
- Supporting Children's Services: around MCA Compliance/DoLS.

On the 5th April 2023 the Department of Health and Social Care (DHSC) reported via their Liberty Protection Newsletter that the government has taken the decision to delay implementation of the Liberty Protection Safeguards to beyond the life of the current Parliament.

In the interim the DHSC recommend health and social care providers should continue to make Deprivation of Liberty Safeguards (DoLS) applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected.

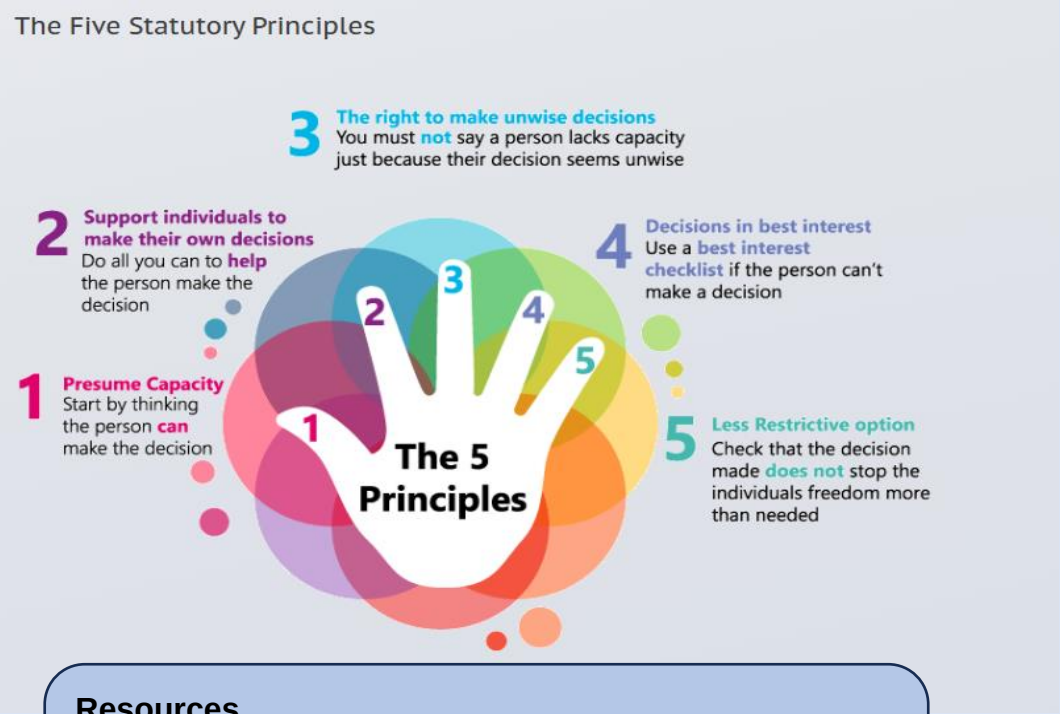
Audience

The London Regional Groups have developed a series of outputs to support achieving the 3 identified key priority areas. This pack provides a range of tools and resources to support health organisations to implement and monitor the application of the Mental Capacity Act

The Mental Capacity Act (Recap)

The Mental Capacity Act has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- By allowing people to plan ahead for a time in the future when they might lack the capacity.



Resources

Mental Capacity Toolkit
Mental Capacity Act Code of Practice
BIHR: Mental Health, Mental Capacity: A Practitioners Guide

Key Messages

- Applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.
- Designed to protect and restore power to those vulnerable people who lack capacity.
- Supports those who have capacity and choose to plan for their future.
- Professionals have a duty to comply with the Code of Practice. It also provides support and guidance for less formal carers.
- The Act's five statutory principles are the benchmark and must underpin all acts carried out and decisions taken in relation to the Act.
- Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity.
- Designed to empower those in health and social care to assess capacity themselves, rather than rely on expert testing – good professional training is key
- Understanding and using the MCA supports practice – for example, application of the Deprivation of Liberty Safeguards

Remember

- The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to 'prove' nothing:
- Outside the court setting, if you are going to take action in the name of P's best interests, you will have to show why you have a reasonable belief that they lack capacity to make the decision(s) in question, and that you have taken reasonable steps to establish this.
- If you are in court, you will need to show the judge why – on the balance of probabilities – it is more likely than not that P lacks capacity to make the decision()s in question.

ICBs and NHS Providers Roles and Responsibilities around MCA / DoLS

All organisations registered with the Care Quality Commission are required to fulfil their responsibilities around the mental capacity act including monitoring practice within the organisation to ensure that people's rights and associated legal requirements are being recognised and met.

All Integrated Care Boards and NHS Providers are required to have a Mental Capacity Act (MCA) Lead within their organisation.

Integrated Care Boards Responsibilities around the Mental Capacity Act: ICBs should:

○	Have access to a designated MCA lead, who is appropriately trained.
○	Have an MCA/DoLS policy or assurance framework in place.
○	Have an MCA Improvement plan in place in accordance with meeting national requirements of the Safeguarding Accountability and Assurance Framework, NICE guidance, and the NHS contract.
○	Ensure appropriate templates for recording MCA are in place for care commissioned by ICB.
○	Ensure MCA practice is referenced and incorporated within all workstreams across the ICB and supporting partners to utilise the same approach, including primary care, secondary care, community care, third sector, all age ranges 16+ and specialist workstreams including CHC, SEND, BCYP, Transforming Care, LD&/orA, Dementia Care, End of Life.
○	Ensure there is a clear MCA/DoLS training strategy to ensure staff are appropriately trained in MCA/DoLS. This should include: • Training content which is co-designed with people with lived experience. • A variety of learning opportunities including scenario or role-based learning • Access to specialist mentoring and advice via named MCA lead. • Updates to reflect any changing case-law or guidance. • Access to a range of resources to improve awareness and keep up to date e.g. staff intranet page
○	ICBs Continuing Healthcare Teams should ensure they have: • A process in place to review of care plans for CHC funded cases to identify potential restrictions which meet the criteria of a deprivation of liberty. • A community DoLS process in place to make applications to the to the Court of Protection, as necessary. • Information (including accessible information) on MCA/DoLS available for families and Individuals.

ICB MCA responsibilities

The ICB responsibilities around MCA should ensure that:

○	Healthcare services provided within the ICB's geographical area demonstrate compliance with the MCA.
○	Services the ICB commissions/joint commissions/co-commissions for people aged over 16 demonstrate compliance with the MCA. This can include services provided outside the ICBs area.

ICB day to day Responsibilities around MCA

Commissioner focus

Contract monitoring

○	Ensure all services commissioned by the ICB have contracts in place with MCA expectations in service level agreements.
○	Ensure all contracts include the appropriate MCA/DoLS requirements within quality monitoring mechanisms and quality monitoring elements.

Patient focus

MCA support and feedback

○	Ensure service users and carers have access to MCA/DoLS information (posters/leaflets/website) which should include accessible information and easy read information. This should include parents and carers of those nearing age 16.
○	While IMCA services are generally commissioned by local authorities on behalf of their geographical area, NHS ICBs are stakeholders of this service and should ensure NHS patients have access to statutory advocacy services as required. NHS services should develop and maintain good working relationships with advocacy providers.
○	Those who may lack mental capacity are not often included in engagement or feedback opportunities. Feedback should be collected from carers and care providers of those who have been involved in mental capacity assessments, best interest decisions or deprivation of liberty safeguards processes.

ICBs and NHS Providers Roles and Responsibilities around MCA / DoLS

ICB day to day Responsibilities around MCA continued.

MCA training, networking and partnership working.

○	ICB has a dedicated MCA Lead to provide technical MCA/DoLS advice to and raise MCA awareness amongst ICB colleagues.
○	Ensure ICB has a clear MCA/DoLS training strategy to ensure staff are appropriately trained in MCA/DoLS.
○	ICBs should work together with local authority and third sector partners to improve the experiences of those impacted by MCA/DoLS. The integrated care system framework may offer useful opportunity to improve joint-working as may existing structures such as safeguarding partnerships. It is important to consider that joint working arrangements should include local authority children's services as well as adult services.
○	ICB MCA Lead keeps up to date with any changes in legislation, best practice and useful MCA/DoLS tools.
○	Where an ICB. employ trained best interest assessors, it will be important to consider how they can best be deployed to support local authority DoLS assessments both for good system working as well as the assessors continued professional development.
○	ICBs may host an MCA/DoLS Improvement group either for health partners or jointly with local authority partners. This may also be delivered through safeguarding networks or other meetings where effective.

Provider focus

Quality assurance and Support

○	Check Providers should have clear governance arrangements to demonstrate compliance with MCA/DoLS, undertake relevant audits and progress any improvements required.
○	Check providers have an MCA Improvement plan in place in accordance with meeting national requirements of the Safeguarding Accountability and Assurance Framework, NICE guidance, and the NHS contract.
○	Collect evidence of MCA/DoLS compliance from lead commissioners regarding providers in local area that the ICB does not have a contract with.
○	Check provider MCA/DoLS policies and procedures are in place and up to date.
○	Check providers have a clear MCA/DoLS training strategy to ensure staff are appropriately trained in MCA/DoLS.
○	Check provider's service users and carers have access to MCA/DoLS information (posters/leaflets/website) which should include accessible information and easy read information. This should include parents and carers of those nearing age 16.
○	Check providers are actively collecting feedback from carers and care providers of those who have been involved in mental capacity assessments, best interest decisions or deprivation of liberty safeguards processes.
○	ICB MCA Lead available to advise providers about complex MCA/DoLS cases (e.g., conflicting views on capacity)
○	Support providers who are not fully compliant with the MCA/DoLS.

ICBs and NHS Providers Roles and Responsibilities around MCA / DoLS

NHS Providers Responsibilities around the Mental Capacity Act: All NHS providers are required to have an MCA lead. This role is responsible for providing support and advice to clinicians in individual cases, and supervision for staff in areas where these issues may be particularly prevalent and/or complex, as per the Deprivation of Liberty Safeguards (DoLS) legislation under the MCA.

NHS Providers are required to:

○	Have a designated MCA lead, who is appropriately trained.
○	Have an up-to-date MCA/DoLS policy in place.
○	All clinical teams should have a clear policy for MCA/DoLS recording including templates where appropriate and prompts within all other relevant documentation.
○	Have an MCA Improvement plan in place in accordance with meeting national requirements of the Safeguarding Accountability and Assurance Framework, NICE guidance, and the NHS contract.
○	Have access to the expertise to provide support and advice to clinicians in individual cases, and supervision for staff in areas where these issues may be particularly prevalent and/or complex, as per the Deprivation of Liberty Safeguards (DoLS) legislation under the MCA.
○	Demonstrate how the organisation, and the services that are commissioned, are compliant with the MCA through audits, effective reporting, and provision of appropriate training.
○	Ensure there is a clear MCA/DoLS training strategy to ensure staff are appropriately trained in MCA/DoLS. This should include: • Training content which is co-designed with people with lived experience. • A variety of learning opportunities including scenario or role-based learning • Access to specialist mentoring and advice via named MCA lead. • Updates to reflect any changing case-law or guidance. • Access to a range of resources to improve awareness and keep up to date e.g. staff intranet page

NHS Provider MCA Responsibilities

NHS Provider are required to have:

○	Ensure services provided within the organisation demonstrate compliance with the MCA.
○	Collect evidence that shows compliance with MCA/DoLS.

NHS Provider MCA lead responsibilities

NHS Provider MCA lead day to day activities

Quality Oversight

○	Lead and undertake in audits to monitor and evidence MCA compliance.
○	Where gaps in compliance are identified ensure, they are referenced in the organisations MCA improvement plan with appropriate actions to support improvement.

ICBs and NHS Providers Roles and Responsibilities around MCA / DoLS

NHS Providers Responsibilities around the Mental Capacity Act continued.

Patient focus

MCA support and feedback

○	Ensure service users and carers have access to MCA/DoLS information (posters/leaflets/website) which should include accessible information and easy read information. This should include parents and carers of those nearing age 16.
○	While IMCA services are generally commissioned by local authorities on behalf of their geographical area, NHS providers are stakeholders of this service and should ensure NHS patients have access to statutory advocacy services as required. NHS services should develop and maintain good working relationships with advocacy providers.
○	Those who may lack mental capacity are not often included in engagement or feedback opportunities. Feedback should be collected from carers and care providers of those who have been involved in mental capacity assessments, best interest decisions or deprivation of liberty safeguards processes.

MCA training, networking and partnership working.

○	The organisation has a dedicated MCA Lead to provide technical MCA/DoLS advice to and raise MCA awareness amongst colleagues.
○	Ensure there is a clear MCA/DoLS training strategy to ensure staff are appropriately trained in MCA/DoLS.
○	NHS Providers should work together with local authority and third sector partners to improve the experiences of those impacted by MCA/DoLS. The integrated care system framework may offer useful opportunity to improve joint-working as may existing structures such as safeguarding partnerships. It is important to consider that joint working arrangements should include local authority children's services as well as adult services.
○	NHS Provider MCA Lead keeps up to date with any changes in legislation, best practice and useful MCA/DoLS tools.
○	Where an NHS Provider. employ trained best interest assessors, it will be important to consider how they can best be deployed to support local authority DoLS assessments both for good system working as well as the assessors continued professional development.
○	Be a member of a MCA/DoLS Improvement group either for health partners or with local authority partners. This may also be delivered through safeguarding networks or other meetings where effective.

Putting the person at the centre

Involving people in decisions about their care is intrinsic to the principles of the MCA and should be evident in every care and support plan. Meaningful Involvement is based on a sharing of power between the person (their family), provider and commissioner.

Person-centred, MCA-compliant care planning (SCIE 2017)

Care and support plans are developed with the person as far as possible. The conversation is led by the person who knows best about their needs and preferences.

Care planning follows a social model of disability.

There is a focus on goals and aspirations, attempts to take into account what the person would like to achieve with their care and support.

- Care planning explores potential for change, opportunities to develop capacity and ability
- Attempts to take account of the person's wishes and views as far as possible.
- The professional provides information about what the service can offer. They agree what will be in the care and support plan. A copy of the plan is made available to the person and/or their representative.
- The emphasis is on safe care that respects a person's right to take risks that they understand.
- The care planning conversation takes place at a time when the person is most or more likely to have capacity.

Resources for the individual and carers

- **BIHR: Mental Health, Mental Capacity: My human rights**
- **A Carer's guide to the Mental Capacity Act**
- **Next of Kin: Understanding decision making authorities**
- **Mencap: The Mental Capacity Act Resource Pack**

Involvement in the cycle of care and support planning

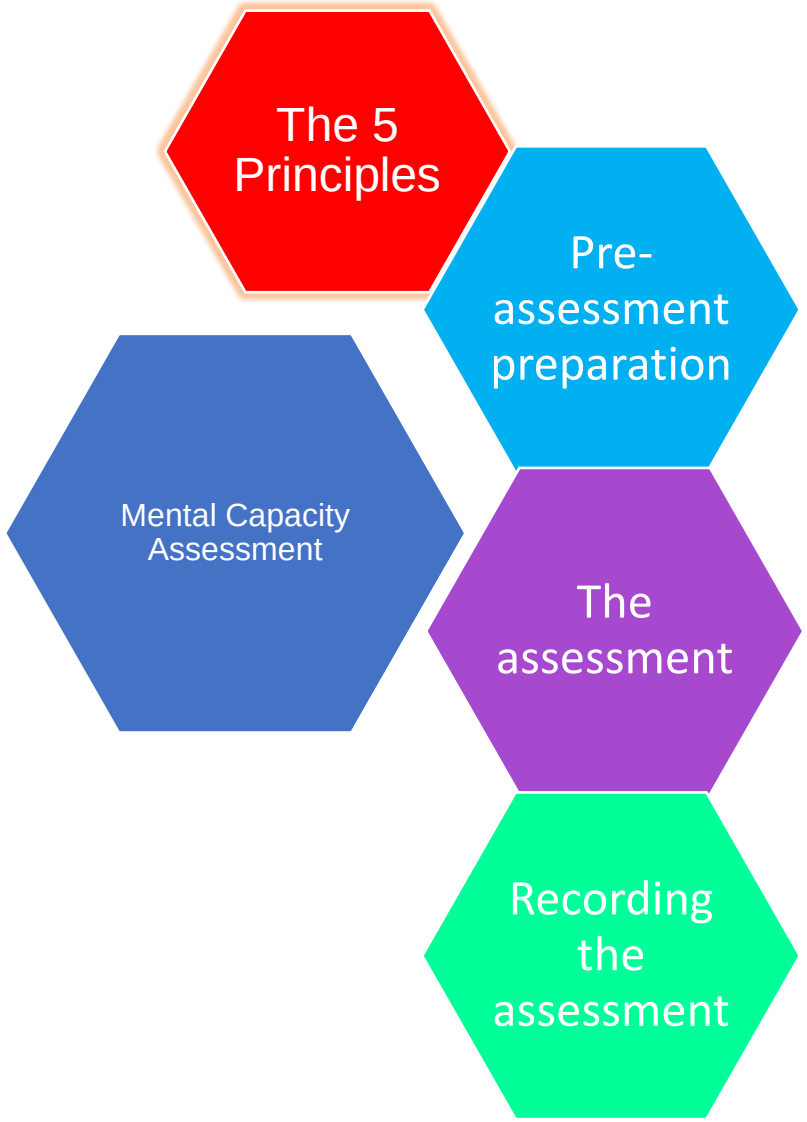
What to look for

- ✓ The person or their family/friends are able to tell you how they were involved in developing the care and support plan and that they felt (and feel) listened to.
- ✓ The person and their chosen representative are aware of the care and support plan and have seen a copy.
- ✓ The care and support plan clearly explains how care and support will be delivered

Person-centred planning (To consider)

- ✓ What the person would like to achieve with their care and support, their goals and aspirations for the future.
- ✓ Find out what is important to the person about how they live their lives now. For example, what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, where they like to go, their preferred routines (such as when they like to get up and go to bed, whether they like a bath or a shower).
- ✓ Details of key life events and dates to assist with chronological orientation.
- ✓ How best to support and involve the person in decision-making.
- ✓ Essential information for continuity of care and for use in emergencies.
- ✓ Roles and responsibilities so that the person receives coordinated care support to meet their needs.
- ✓ Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted.
- ✓ The associated benefits and risks of each option

Undertaking a Mental Capacity Assessment



Keep at the forefront the 5 Principles

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who does not have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

Resources

- **HRCH Capacity Coach videos. Introduction , Decision-making & When capacity is complicated**
- **British Institute of Human Rights Guides**
- **Lancashire SAB MCA Assessment Practice Guidance Toolkit**
- **Lancashire SAB MCA E-book**
- **Midnight Law: Pitfalls In the Assessment of Mental Capacity**
- **The Royal College of Emergency Medicine MCA Good Practice Guidance**
- **Mental Capacity Toolkit**

Undertaking a Mental Capacity Assessment

Pre-assessment preparation

The assessor should be clear about:

- Are you the best person to undertake the assessment?
- The decision to be made.
- The individual's communication needs.
- Any reason to doubt capacity.
- Record concerns about the person's decision-making ability.
- If the decision can wait until the person has regained mental capacity.
- Is there a valid and applicable advance decision?
- Have the relevant information ready (reasonably foreseeable consequences for the person for whatever decision they make or fail to make.)
- Engage, motivate, and enable the person to make the decision themselves. Even if this fails, continue to include the person in your assessment conversation.

The Assessment

Undertaking a Mental Capacity Assessment

NHS

Conducting the assessment	
Question	**Supporting Prompts**
Does the individual understand the information relevant in basic terms to make the decision?	• Explain why you carrying out the assessment and what the decision is to be made • Ask P about their what they understand from the information that has provided to help make the decision. • Does it appear that P has been provided with all the relevant information (in an appropriate format) they require to make the decision. • Identify the key details that need to be understood by P.
Can the individual use or weigh up the information as part of the process of making the decision?	• Ensure that P has have the clear details of the choices available and the consequences of each choice (the risks and benefits). • Is the individual being influenced by other people's views, perspective on the decision. • If the individual cannot reach a decision this could evidence, they are not able to weigh up the information. • If the individual can set out the risks and benefits of each choice but is unable to apply it to their circumstances this could be deemed, they are not able to weigh up the information.
Can the individual retain that information for long enough to make a decision?	• MCA (2005) Section 3(3) states that people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide – it depends on what is necessary for the decision in question. • Items such as notebooks, photographs, posters, videos, and voice recorders can help people record and retain information.
Can the individual communicate their decision?	• Ensure you are aware of the individuals communication needs. • Decisions can be communicated by any means possible (e.g. verbal or sign language, gesture, drawing, writing, etc.)
The 'diagnostic test' Does the person have an impairment of, or disturbance in the functioning of, mind or brain? Is the person's inability to make the decision because of the identified impairment or disturbance	• The impairment or disturbance in the functioning of the mind or brain can be temporary or permanent, and the MCA Code gives some examples of what may amount to an impairment or disturbance in the functioning of the mind or brain. can include confusion, drowsiness, concussion, and the symptoms of drug or alcohol as well as formally diagnosed conditions. This is sometimes referred to as the 'diagnostic test' but this a little misleading, as a formal diagnosis is not always necessary, as long as there is clear evidence that there is an impairment or disturbance. • It is not sufficient to simply say that the person has a disturbance or impairment of mind, the assessor has to show why and how the disturbance or impairment of mind is causing the inability to make the decision(s) in question. This is sometimes referred to as the 'causal nexus'. • Is the impairment of, or disturbance in the functioning of, mind or brain temporary or permanent.

Undertaking a Mental Capacity Assessment

Recording The Assessment

Resources:
- **Edge training MCA Form**
- **39 Essex Chambers: Carrying Out and Recording Capacity Assessments**

Recording a Capacity Assessment

A good record of a capacity assessment that reaches the conclusion that a person lacks the capacity to make a specific decision will show that you have:

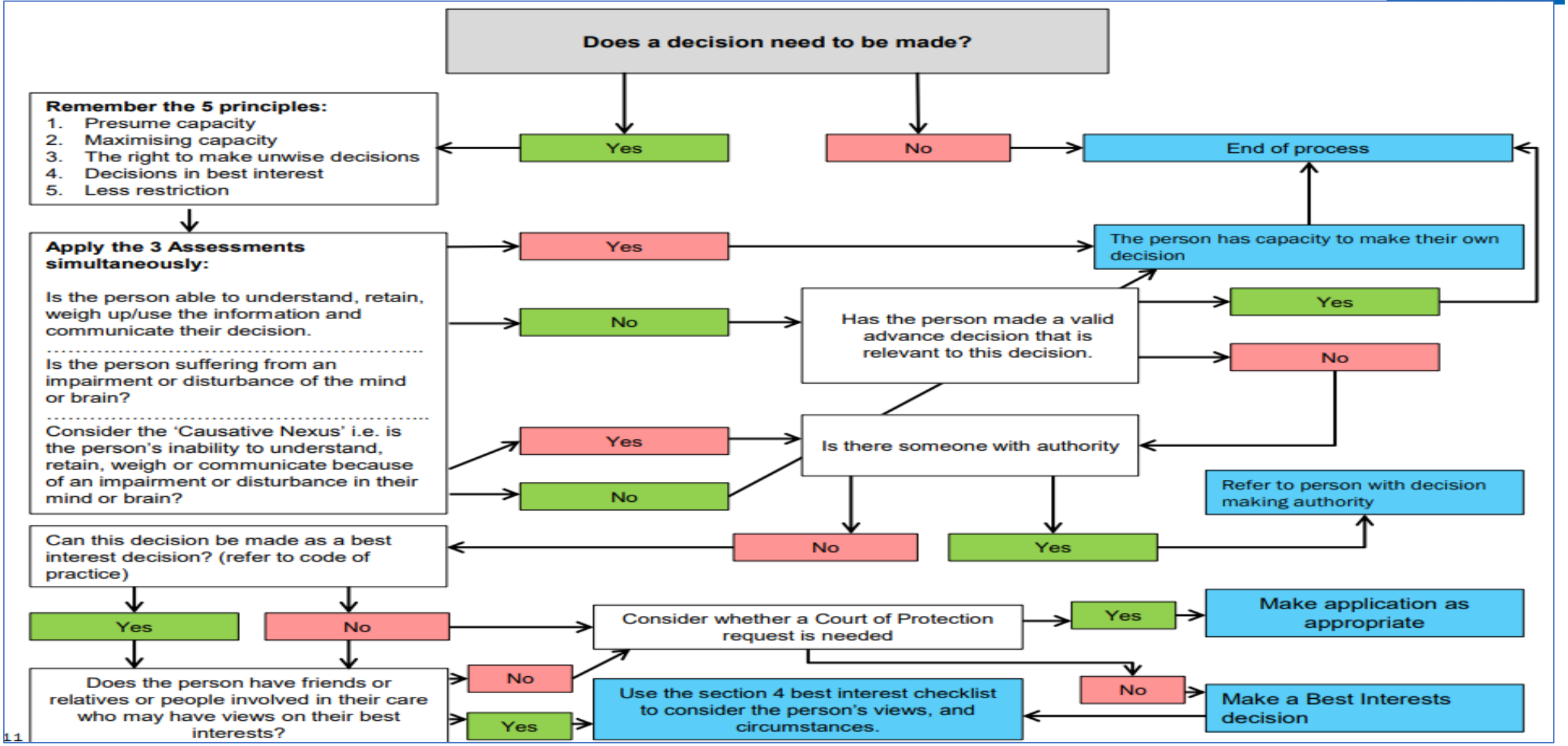
- Been clear about the capacity decision being assessed;
- Ensured that the individual (and you) have the clear details of the choices available (e.g. regarding treatment options; between living in a care home and living at home with a realistic package of care);
- Identified the key details the individuals needs to understand.
- Ensure balance between managing the risk and free choice (protection imperative vs free choice imperative)
- Demonstrated the efforts taken to promote the individuals' ability to decide and, if unsuccessful, explained why;
- Recognised that assessment is not necessarily a one-off matter, and that you have taken the time to undertake to gather as much evidence as is required to reach your conclusion – including, for instance, returning to have a further conversation with the individual or obtaining supportive evidence;

Evidenced each element of your assessment:

- Why could the individual not understand, or retain, or use/weigh, or communicate in spite of support provided?
- What is the impairment/disturbance? Is it temporary or permanent?
- How is the inability to decide caused by the impairment/disturbance (as opposed to something else)?

Answered the question: why this is an incapacitated decision as opposed to an unwise one?

Applying the Mental Capacity Act Flowchart



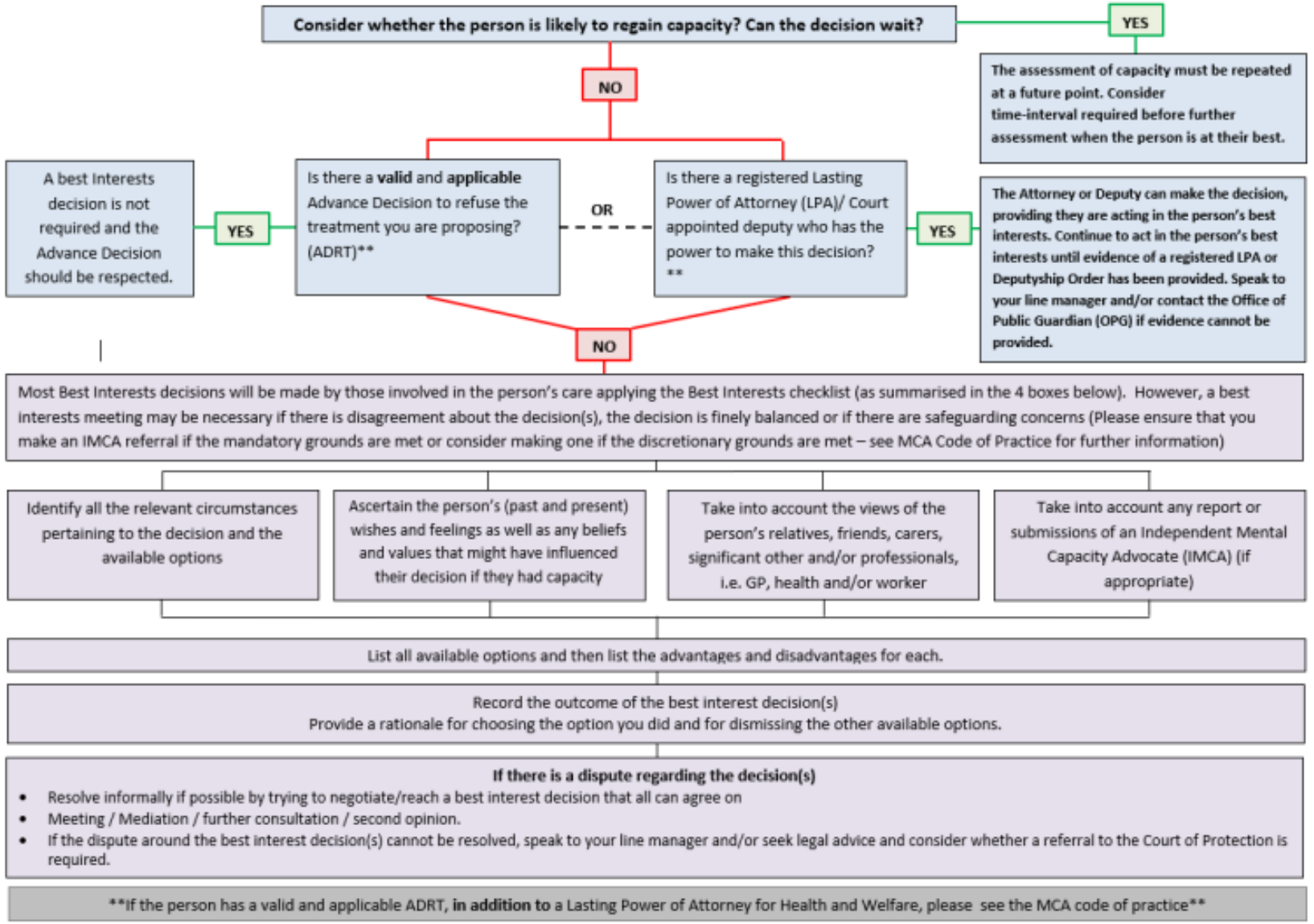
Bexley SAB MCA Toolkit

Best Interest Decision Making

When someone is deemed to lack capacity for a particular decision and it is unlikely, they will regain capacity, or the decision cannot wait. "Best interest decision making“ may be required.

This means making choices for someone else based on what would benefit them the most. Consider their wishes, feelings, and values. Choose options that promote their well-being and are the least restrictive. Regularly review and adjust decisions as needed."

Resources
Lancashire SAB Restrictive Practice Guidelines



Waltham Forest SAB MCA Guidance

Decisions Excluded under MCA

Decisions concerning family relationships (Section 27) Decisions that must not be made on someone else's behalf are:

- consenting to marriage or a civil partnership.
- engaging in 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 the making of an adoption order.
- discharging parental responsibility for a child in matters not relating to the child's property.
- giving consent under the Human Fertilisation and Embryology Act 1990.

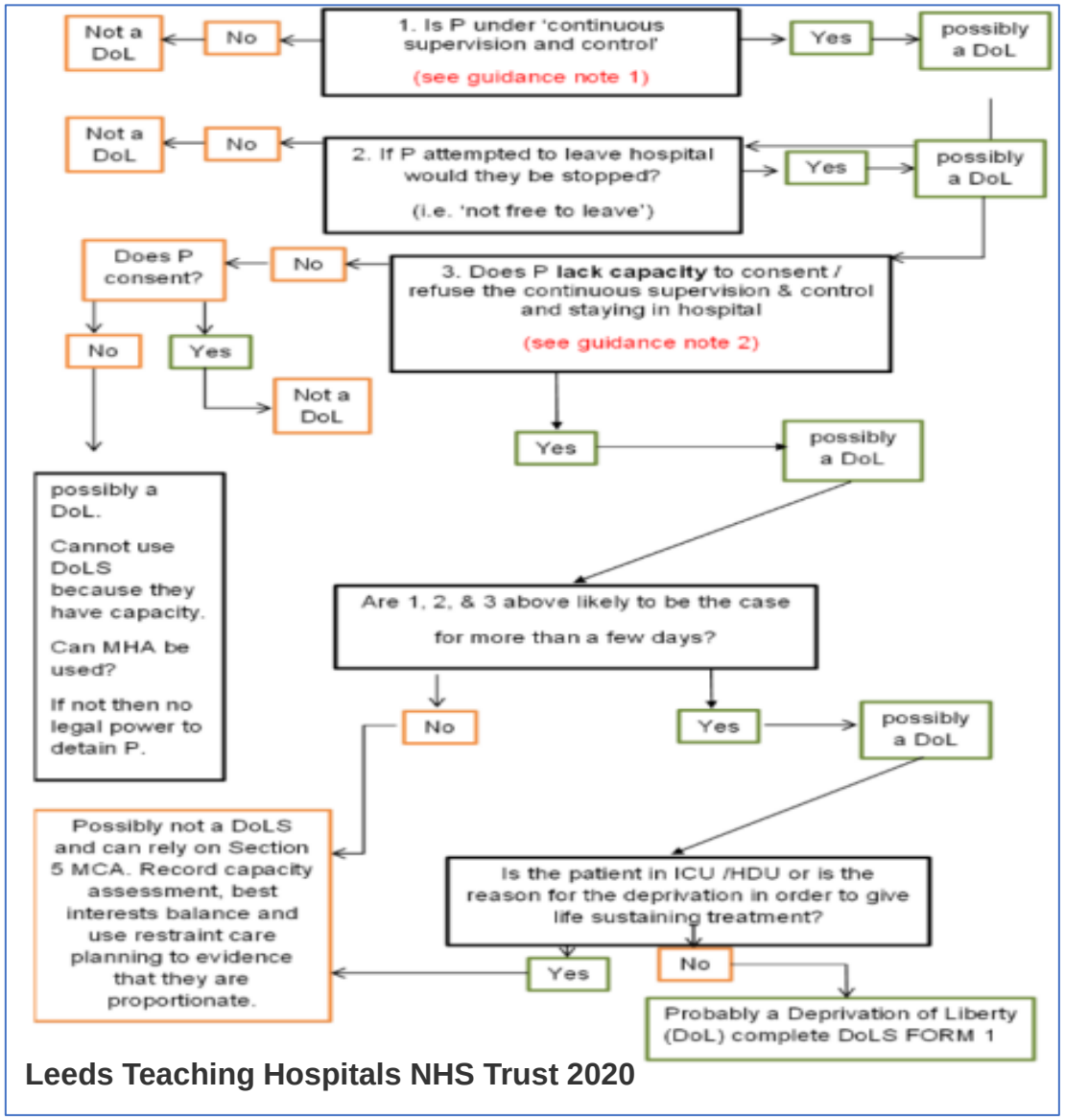
Mental Health Act matters (Section 28) Where a person who lacks capacity to consent is currently detained and being treated under Part IV of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- give the person treatment for mental disorder.
- consent to the person being given treatment for mental disorder.

Further guidance is given in chapter 13 of the Mental Health Act 1983 (amended 2007) Code of Practice.

Arranging legal representation If you think a person who lacks capacity needs legal representation, seek advice from your legal department.

Recognising a Deprivation of Liberty



Leeds Teaching Hospitals NHS Trust 2020

Guidance Note 1 - 'Continuous supervision and control'. It is vital to identify ALL the restraints and restrictions in place for the patient. Restraint is defined in law as:

Using force – or threaten to use force – to do something that they are resisting, or restricting a person's freedom of movement, whether they are resisting or not.'

This includes routine interventions such as Bedrails, mittens, enhanced supervision, locked ward doors, sedation or simply telling a patient they will be prevented from leaving the ward on their own ARE all restraint measures.

'Continuous supervision and control' is measured by looking at the patient's care plan overall and asking: Are there lots of small restraint measures which combined amount to 'continuous supervision and control'? Is there just one or two restraints being used but for an intense / long time e.g., mittens 24/7 or consistently for days? Overall are we in control of where the patient goes and how long for?

Guidance Note 2 - Valid consent. If the patient lacks capacity to consent/refuse the restrictions in place that amount to a deprivation of their liberty, then nobody else can provide valid consent in their place.

- Lasting Powers of Attorney/Court appointed Deputies cannot consent, whilst they can consent/refuse treatment and care, cannot consent to restrictions that would otherwise be a deprivation of liberty – dols would still be required in such cases.
- 16/17-year-old patients: Parent / Person with Parental Responsibility cannot consent to arrangements that would otherwise amount to a deprivation of liberty. Authorisation for the deprivation would still be needed even where parents agree with the restrictions. This might mean seeking authority from the courts (as the current DoLS process does not accommodate 16/17-year-olds)
- 0–15-year-olds: MCA does not apply to this age group, but they may subject to restrictions that amount to a deprivation of liberty. It is unclear (untested in court) whether a parent's consent to restrictions/restraint would avoid it being a deprivation of the child's liberty. Whilst this might sit within the normative zone of parental responsibility for very young children, it is less clear that there is 'bright line' divide between 16-year-olds and 14/15 years old for example. In practice this means that if you are depriving a patient of their liberty who is 0-15, you should record the consent for the deprivation (restrictions/restraint) by the person with Parental Responsibility, your assessment of the child competence to make such decisions, the views of the child and seek advice as above.

Guidance Note 3 - duration of restrictions and their setting

DoLS is about authorising the on-going use of restraint/restrictions that may breach Article 5 Right to liberty in Human Rights law. DoLS is not designed to authorise short periods of restraint or restriction. The Mental Capacity Act section 6 authorises you to take actions for a patient who lacks capacity in their best interests, including restraint that is proportionate to protect them from harm.

If you as an MDT believe that the restrictions/restraints are only likely to be needed for a few days (e.g. post-surgical delirium or drug detox where the situation may be very different in a few days), then there is no need to apply for DoLS.

Equally in many patients whose incapacity has coincided with the illness that has caused them to come into hospital, their incapacity is clinically explicable by their physical illness. On recovery from their illness, they would be expected rapidly to recover their capacity. In this patient group, you do not need to make an automatic DoLS application. The DoLS process can take some time, once an application is sent to the council; and the Code says that you should only grant yourself an Urgent DoLS authorisation (page 6 of the Form 1) if you believe a Standard DoLS will be needed. So for patients whose initial presentation to hospital might mean they lack capacity and need significant restraint, but whose situation is likely to change quickly, we would suggest recording your capacity assessment and best interests' decision robustly (using LTHT MCA Procedure) and review the situation regularly rather than completing a DoLS application that may not be needed by the time it is processed/assessed.

ICU - A key Court Case (R Ferreira v HM Coroner) has determined that if treatment for a physical illness in, an emergency/life sustaining treatment situation, is the cause of incapacity and the restrictions, then there is no need to apply for DoLS. This means that we would not expect automatic DoLS applications from Intensive Care settings or for life sustaining treatment in an emergency.

Community Deprivation of Liberty

What is a Community Deprivation of Liberty?

- A person living within the community who has been determined to lack capacity to make decisions for themselves about their support and accommodation.
- The detention is 'imputable to the state' , care and treatment is imputable to the state if it has been arranged or provided by the Local Authority / NHS.
- The individual is receiving a package of support. ICBs are responsible for making DoL applications for Individuals in receipt of Continuing Healthcare funded care in own homes/supported living.
- The below Acid Test is met.
- Where the Acid Test met a person is considered to be being deprived of their liberty?

What constitutes a deprivation of liberty?

The Acid Test tells us that a person is being deprived of their liberty because they are confined.

For every person who has restrictions and deprivations within their support, we must always consider:

- Is this the least restrictive option?
- Is this deprivation in the person's best interests?

If we fail to apply this criteria, we are at risk of acting unlawfully.

Points to consider re are the restriction necessary and proportionate:

- Are the restrictions used frequently and/or for prolonged periods of time?
- Do the restrictions impact significantly on the person's freedom of movement?
- Could there be a significant psychological impact on the person, e.g., are they objecting or distressed?
- Are relatives or carers concerned about the restrictions placed on the individual?
- Are the restrictions considered to be in the person's best interests?
  - Are they to protect the individual from harm?
  - Are the restrictions a proportionate response to the likelihood and severity of the potential harm?

Resources:

- **NHS Sussex Guide to DoL Leaflet**
- **The Law Society: Quick reference guide to identifying a deprivation of liberty in the supported living setting**
- **The Law Society: Quick reference guide to identifying a deprivation of liberty in the home setting**
- **Age UK Deprivation of Liberty Safeguards Factsheet**

Court of Protection

- **A basic guide to the Court of Protection**

Children and Young People

Section 12 of the Mental Capacity Act 2005 code of practice for full guidance. It is important that everyone is clear which safeguarding procedures should be implemented in situations involving 16–17-year-olds.

Resources for staff
- **NHS Guidance: Consent to treatment**
- **BMA Childrens and Young People's toolkit**
- **Guidance on use of Mental Capacity Act 2005.pdf(kirkleessafeguardingchildren.co.uk)**
- **Lancashire SAB Framework for capacity and consent for young people.**

a. Children – aged under 16 years

The Act does not generally apply to people under the age of 16. There are 2 exceptions:

- The Court of Protection can make decisions about a child's property or finances if the child lacks capacity to make such decisions and is still likely to lack capacity to make financial decisions when they reach the age of 18.
- Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

b. Young People – aged 16-17 years

Most of the act applies to young people aged 16-17 years of age. There may be an overlap with The Children Act 1989. For the Mental Capacity Act 2005 to apply to a young person they must lack capacity to make specific decisions as set out above. There are 3 exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over.

c. Care and treatment of young people aged 16 or 17

The Family Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. This also applies to any associated procedure i.e. investigations, anaesthesia or nursing care.

As with adults, decision makers should assess the young person's capacity to consent to the proposed treatment or care. If the young person lacks capacity to consent because of an impairment or disturbance of the brain, then the MCA will apply in the same way as it does who are 18 and over. If they lack capacity for any other reason for example because they are overwhelmed by the implications of the decision, the act will not apply to them, and the legality of any treatment should be assessed under common law principles. The act does not apply to some rare types of procedure for example organ donation or research. In these cases, anyone under 18 is presumed to lack legal capacity, subject to the test of 'Gillick competence'.

London MCA Competency Framework

The presumption of capacity should be the underpinning ethos of the interactions between healthcare staff whenever they are required to interact and/or build relationships with any member of the public. In some circumstances there may be concerns which lead staff across a range of settings to work with individuals who may, for a whole host of reasons, be unable to decide for themselves. In these cases, staff need to understand, and apply, the framework of the Mental Capacity Act to their areas of responsibility, ensuring the individual's rights in situations where someone needs additional support or safeguards to be put in place. Understanding of the Mental Capacity Act legislation relevant is essential to core health care practice and competencies. Sufficient time is required to ensure that Mental Capacity Act competencies are met. Mental Capacity and Deprivation of liberty training may be delivered as a standalone training as well as inclusion in both child and adult safeguarding training. It is important that Mental Capacity Act competencies are included to enable people to fulfil their roles. This document is not a comprehensive list of mental capacity and deprivation of liberty practice competencies.

Recommended framework, training and resources:

- National Mental Capacity Act Competency Framework for Professional Health & Social Care Staff (Qualified non specialist) which includes ICB
- The NICE guidance for decision-making and mental capacity.
- Mental Capacity Toolkit
- Mental Capacity Act - eLearning for healthcare (e-lfh.org.uk)
- Mental Capacity Act (MCA) training courses | SCIE

MCA Level 1 Requirements: This is the minimum level required for all staff including, agency and voluntary staff, and specified contracted providers, working in any health or social care setting (NHS or non-NHS) who have regular contact with patients, clients, their families or carers, or the public:

Staff Groups: All health care staff receptionists, administrative staff, caterers, domestic and transport staff, porters, community pharmacist counter staff, peer support workers and maintenance staff, board level executives and non-executives, non-clinical staff working in primary health care settings

Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
• Awareness of roles and responsibilities in relation to the Mental Capacity Act • Awareness of the principles of the MCA • Recognise when someone may lack capacity and know who to contact within the organisation for further advice and support on MCA • Awareness of Best Interest Decision making • Awareness of deprivation of liberty and who to contact within the organisation for advice. • Awareness of the role of attorneys, deputies and Independent Mental Capacity Advocates.	• Be able to support patients to make day to day decisions within the framework set by the MCA. • Be able to explain their reasonable belief that someone lacks capacity • Recognise when a formal assessment of capacity is needed and know who is the decision maker • Have a basic understanding of the concept of deprivation of liberty and who how to contact the DoLS teams for advice • Be aware of the role of attorneys, deputies and IMCAs	• E-learning • Shadowing • Observed assessment • Reflective Logs • Team Discussions • Online Resources

Competencies for the Mental Capacity Act are currently being strengthened in the revised Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document. This framework will be reviewed following publication of the Intercollegiate document

London MCA Competency Framework

MCA Level 2 Requirements: This is the minimum level required for all staff including, agency and voluntary staff, and specified contracted providers, working in any health or social care setting (NHS or non-NHS) who have regular contact with patients, clients, their families or carers, or the public:

Staff Groups: This includes administrators for safeguarding teams, health students, phlebotomists, pharmacists, 111/999 communications centre staff, orthodontists, dentists, dental care professionals*, audiologists, optometrists, nursing associates, clinical researchers, allied health professionals, ambulance call taking staff, staff who work in virtual/online health settings who provide any health care online, registered nurses**, medical staff and GP practice managers

Please note this list is not exhaustive and can be reviewed by the MCA Lead for the service or organisation and included in the training needs analysis.

Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
All staff at Level 2 should have the knowledge, skills, attitudes and values outlined for Level 1 and should be able to demonstrate the following: • Understands mental capacity legislation as relevant to the country of practice. • Understand organisational policies and procedures. • Understand the importance of seeking consent, and how to proceed if a person might lack capacity to give or refuse their consent to any proposed intervention • Understand when capacity needs to be assessed (Recognise that capacity should only be assessed where a concern about capacity is identified.) • Ability to support patients to make day to day decisions within the framework set by the MCA. • Awareness of when and where to record application of the mental capacity act. • Recognise when a more detailed assessment of capacity for a more complex decision is required and when to seek advice. • Understands the importance of establishing, acting or making a decision in person's best interests as reflected in legislation and key statutory and non-statutory guidance. • Demonstrates an understanding of the concept of deprivation of liberty and can apply a working knowledge of the deprivation of liberty safeguards and community deprivation of liberty • Recognise restrictions and actions to take to explore how they can be reduced. • Understands the different roles, bodies and powers supporting the MCA. • Demonstrates an understanding of advance decisions and an ability to assess if they are valid and applicable and when to seek advice. • Condition-specific knowledge related to advance care planning, where appropriate. • Ability to direct people (individuals and their family and friends) to sources of advice and information re MCA/DoLS	• Understand policies and procedures (including roles and responsibilities) • recognise that capacity should only be assessed where a concern about capacity is identified. • Recognise when a more detailed assessment of capacity for a more complex decision is required and when to seek advice. **Understand the role of** • Court of Protection, • attorneys, • deputies • Independent Mental Capacity Advocates • Best Interest Assessors (under the Deprivation of Liberty Safeguards). • the public guardian/Office of Care and Protection (OCP) • Demonstrates an understanding of advance decisions and an ability to assess if they are valid and applicable and when to seek advice • Demonstrates an understanding of the concept of deprivation of liberty and can apply a working knowledge of the deprivation of liberty safeguards.	• E-learning • Face to Face Training • Shadowing/Mentoring • Observed assessment • Team discussions • Professional Group Discussions • Reflective Supervision • Action Learning Sets

Competencies for the Mental Capacity Act are currently being strengthened in the revised Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document. This framework will be reviewed following publication of the Intercollegiate document

London MCA Competency Framework

MCA Level 3 Requirements: This is the minimum level required for all Registered health care staff including, agency and voluntary staff, and specified contracted providers, working in any health or social care setting (NHS or non-NHS) who have regular contact with patients, clients, their families or carers, or the public. This level is also applicable to commissioners of healthcare services and quality teams within ICBs, working with adults who engage in assessing, planning, delivering care and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).

Staff Groups: This includes safeguarding professionals, medical staff, general practitioners, registered nurses, urgent and unscheduled care staff, psychologists, psychotherapists, adult learning/ intellectual disability practitioners, health professionals working in substance misuse services, ambulance staff, sexual health staff, care home managers, health visitors, midwives, dentists, pharmacists with a lead role in adult protection, ICB Commissioners

Please note this list is not exhaustive and can be reviewed by the MCA Lead for the service or organisation and included in the training needs analysis.

Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
All staff at Level 3 should have the knowledge, skills, attitudes and values outlined for Level 1&2 and should be able to demonstrate the following: • Ability to assess capacity and coordinate best interest decisions within the framework of the relevant legislation. • Understands the decision and time specific nature of capacity and hence the need to reassess capacity appropriately. • Able to communicate effectively with adults to recognise and to ensure those lacking capacity to make a particular decision or with communication needs have the opportunity to participate in decisions affecting them. • Ability to support individuals to make complex decisions within the framework set out by the MCA. • Able to seek specialist communication support where necessary. • Understands who needs to be included or consulted within making decisions in a person's best interests. • Recognises restrictions being placed on an individual and assess whether these are proportionate to the person's needs and risks of harm. • Able to identify when an individual is being deprived of their liberty and make appropriate referrals. • Able to contribute to community deprivation of liberty assessments. • Ability to produce clear records of assessments of capacity and best interest decision making. • Able to support people to plan for when they may lack capacity in the future. • Understand the advantages, challenges, and ethics of advance care planning, and how to discuss these with the person and their carers, family and friends. • Ability to determine whether an advance decision is valid and applicable. • Ability to determine how and when to have potentially difficult conversations about loss of autonomy advance care planning or death.	• detailed knowledge and understanding, including practice experience, of the first principle. • A working knowledge of the capacity assessment process. • Undertake complex capacity assessments and report findings to multidisciplinary teams, commissioners or managers. • Identify salient information, appropriate assessor, and advice colleagues in staff groups 1-3, as appropriate to role and function, on MCA practice and supported decision making. • Support people to plan for when they may lack capacity in the future, including knowledge of advance decisions, lasting powers of attorney and excluded decisions. • Use highly developed communication and rapport-building skills to help individuals make (or participate in) decisions for themselves. • Recognise, assess and, where appropriate, intervene in situations where coercion is impacting on a person's ability to decide.	• E-learning • Face to Face Training • Bespoke Specialist Sessions • Shadowing/Mentoring • Observed assessment • Team discussions • Professional Group Discussions • Reflective Supervision • Action Learning Sets

Competencies for the Mental Capacity Act are currently being strengthened in the revised Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document. This framework will be reviewed following publication of the Intercollegiate document

London MCA Competency Framework

MCA Level 4 Requirements: This is the minimum level required for all organisational MCA/DoLS Leads with an aim to provide leadership, management and/or appropriate governance within organisations and ensure organisational policies and procedures are legally compliant and promote best MCA practice

Staff Groups: This level applies to MCA / DoLS leads NHS /Health organisations, Board and Senior Management MCA / DoLS portfolio holders.

Please note this list is not exhaustive and can be reviewed by the MCA Lead for the service or organisation and included in the training needs analysis.

Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
All staff at Level 4 should have the knowledge, skills, attitudes and values outlined for Level 1,2,3 and should be able to demonstrate the following: • Promote the principles of the MCA within the organisation as appropriate to role. • Ensure organisational policies and procedures are aligned to the requirements of the MCA to guide staff to work within the appropriate legislative framework. • An advanced understanding of mental capacity legislation, information sharing, information governance, confidentiality, and consent. • Knowledge of how to identify salient information and appropriate assessor, decision-maker and support and advice others • Able to advise colleagues as appropriate to role and function on MCA practice and supported decision making • Recognise, assess and, where appropriate, intervene in situations where coercion is impacting on a person's ability to decide. • Scrutinise capacity assessments to ensure robustness of process and evidence as impacted by relevant case law and policy updates. • Scrutinise and mediate application of the MCA in complex situations. • A thorough understanding of positive risk-taking and strengths-based approaches as a means of risk management in cases where individuals with capacity choose to make unwise decisions. • Promote a culture of positive risk and risk management within the organization and challenge restrictive practices. • Chair best interests' meetings where appropriate to role and context where it is deemed an independent chair or lead practitioner would be appropriate according to local processes • Ability to chair best interest meetings where appropriate to the role • Identify and act in situations where a court of protection referral is needed • Knowledge of which decisions require input from the court of protection • Understand the court of protection and other legal systems relating to deprivation of liberty. • Knowledge of how and when to seek legal advice • Ability to advise colleagues on MCA practice and court of protection applications • Liaise with and instruct solicitors, as appropriate to role, where an individual's rights are being infringed and court of protection intervention is required.	• Provide leadership, specialist knowledge and scrutiny in relation to MCA and DoLS within your organisation. • Ability to Identify and implement areas of improvement to operational services required following changes in legislation and case law. • Lead on the provision of advice and support to partner agencies. • Lead and monitor compliance with the Mental Capacity Act 2015 through training, audits, quality assurance and awareness raising. • Ability to advise Senior Leaders on risks, legal and procedural changes affecting the organisation's responsibility and commissioned services risks in relation to MCA/DOLS/LPS. • Advanced understanding of the different roles, bodies and powers supporting the MCA and procedures re access and to how to advise staff re navigation. • Ability to lead and develop policies and procedures for MCA.	• E-learning • Bespoke Specialist Training • Case Law Updates • Peer Supervision with other MCA Leads. • Leadership Training • Quality Improvement Training • MCA Networks

Competencies for the Mental Capacity Act are currently being strengthened in the revised Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document. This framework will be reviewed following publication of the Intercollegiate document.

London MCA Competency Framework

MCA Level 5 Requirements: This training is for specialist roles and MCA Leads and should include leadership, appraisal, supervision training and the context of other professionals' work.

Staff Groups: This level applies to MCA / DoLS leads NHS /Health organisations, Board and Senior Management MCA / DoLS portfolio holders.

Please note this list is not exhaustive and can be reviewed by the MCA Lead for the service or organisation and included in the training needs analysis.

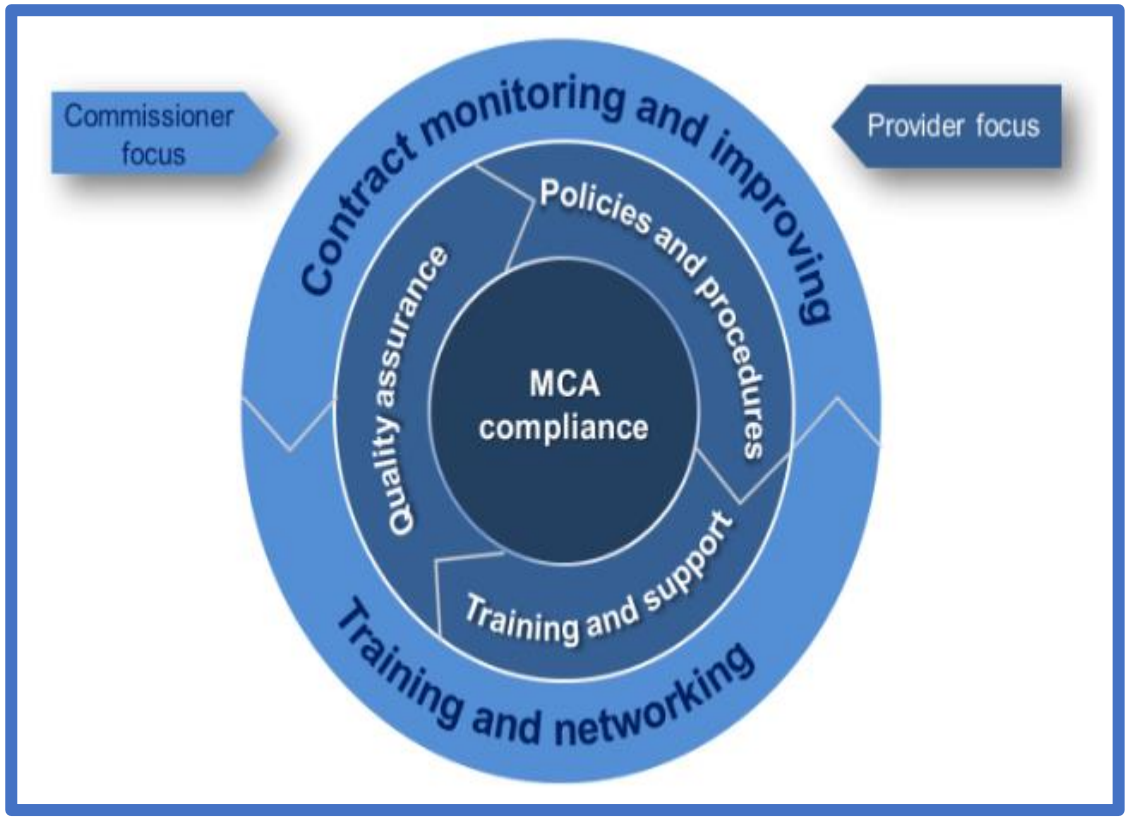
Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
• Lead on mental capacity and deprivation of liberty to ensure that supervision, training and quality assurance includes consideration of the mental capacity act. • Strategic leadership on continuous improvement in MCA/DoL • Promote supported decision-making, co-production and participation in care, treatment, and where appropriate to role and context, organisational and strategic development. • Promote a culture of positive risk-taking and risk management ensuring policy, procedures and practices support staff to take a rights-based approach to decisions and interventions. • Remain aware and up to date with case law impacting on the MCA and DoLS practice and cascade these to staff groups as appropriate to role and context • Ability to support or advise other professionals with legal documentation/court responsibilities within their organisations.	• Provide leadership, specialist knowledge and scrutiny in relation to MCA and DoLS within the. organisation. • Provides advice to Senior Leaders on risks, legal and procedural changes affecting the organisation's responsibility and commissioned services risks in relation to MCA/DOLS/LPS. • Advanced understanding of the different roles, bodies and powers supporting the MCA and procedures re access and to how to advise staff re navigation.	• E-learning • Bespoke Specialist Training • Case Law Updates • Peer Supervision with other MCA Leads. • Leadership Training • Quality Improvement Training • MCA Networks

MCA Board Level Requirements
Staff Groups: This level training is for Chief Executive Officers, Trust Chairs, Health Board Executives, Medical Directors, Trust Executives, Executive level staff, non-executive directors/members, commissioning body directors including those in the independent and voluntary sectors.

Please note this list is not exhaustive and can be reviewed by the MCA Lead for the service or organisation and included in the training needs analysis.

Core Skills and Knowledge	Competency Required	Learning Opportunities to support development
• All board members/commissioning leads should have Level 1 core competencies in safeguarding (including MCA and DoL) and must know the common presenting features of abuse, harm and neglect and the context in which it presents to health care staff. In addition, board members/commissioning leads should have an understanding of the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff's roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding. Essentially the board will be held accountable for ensuring adults at risk in the organisations care receive high quality, evidence-based care and personalised safeguarding. • Understand the organisations legal obligations in relation to deprivation of liberty including the positive obligation of public bodies to take steps to regularize and deprivation as well as associated liability.	• Awareness of roles and responsibilities in relation to the Mental Capacity Act • Awareness of the principles of the MCA • Recognise when someone may lack capacity and know who to contact within the organisation for further advice and support on MCA • Awareness of Best Interest Decision making • Awareness of deprivation of liberty and process when a deprivation of liberty is identified. • Awareness of the role of attorneys, deputies and Independent Mental Capacity Advocates. • Understanding of the obligations and duties the NHS as a public sector body has to Respect, Protect and Fulfil the rights that people have under the Human Rights Act 1998	• E-learning • Bespoke Specialist Training

MCA Quality Assurance Framework



All organisations registered with the Care Quality Commission are required to fulfil their responsibilities around the mental capacity act including monitoring practice within the organisation to ensure that people's rights and associated legal requirements are being recognised and met

The MCA Quality Assurance framework outlines what is required to ensure MCA compliance from a provider and commissioner perspective.

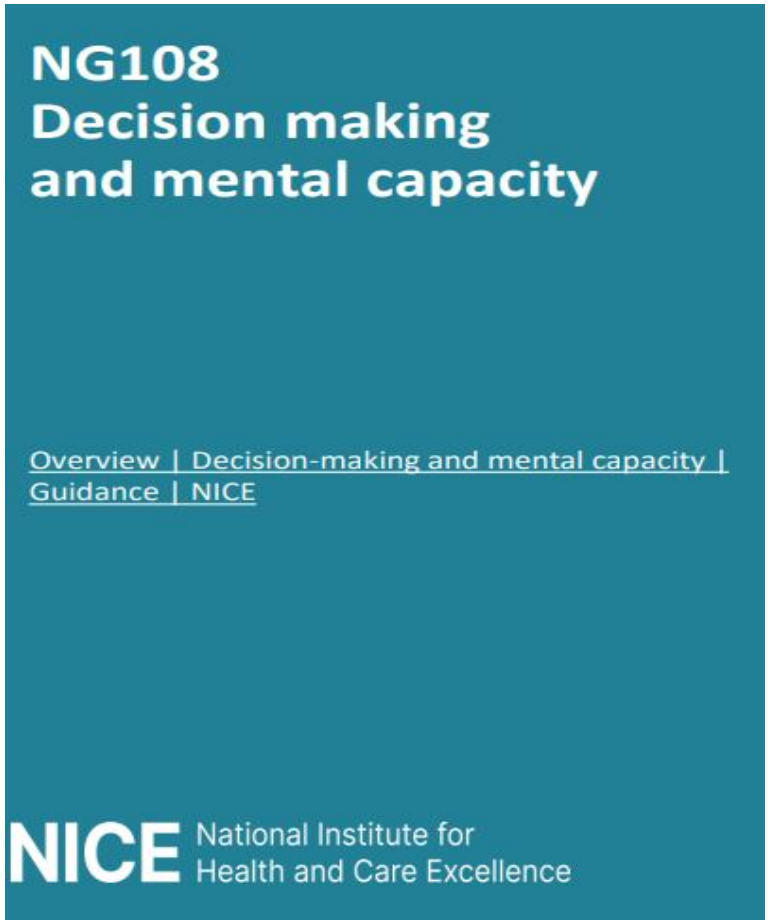
It is important that ICBs and providers have:

- MCA policies and procedures in place that provide the correct framework for staff to follow.
- MCA training and support to translate MCA policies and procedures into practice.
- Quality assurance mechanisms in place that check MCA processes are carried out appropriately.

Good practice ICB/provider MCA training and support and quality assurance should involve service users. For example, service users should be provided with information to understand the MCA and feedback about their experience should be collected.

The following are suggested methods and supporting resources that can be utilised to monitor compliance of MCA.

MCA Quality Assurance Framework



The NICE Decision Making and Mental Capacity Audit and Service Improvement Template can be utilised to establish clear quality standards/expectations within an organisation around MCA.

Each organisation should have a quality assurance plan in place which sets out methods on how MCA compliance is monitored. This can include:

- Data
- Training Figures
- Policies.
- Audits of care records.
- Observations of practice.
- Supervision of staff.

A suite of tools and templates for local adaptation can be found here on the London Region Safeguarding Future NHS Page

Commissioning/Providing an MCA compliant Service or Activity.

The following has been adapted from the ADASS Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance is intended to assist commissioners and providers to consider to support the provision of an MCA compliant service or activity.

By referring to the suggested points for consideration, commissioners and providers can produce documents which have an MCA focus and measure a services compliance with the requirements of the MCA. This will help to embed the principles across the organisation and promote the rights of people who use services. Commissioners/providers should adapt the questions within each area to suit their target audience.

General MCA suggested areas to question:

- Does the ICB/Provider fulfil expectations set out in the ICBs and NHS Providers Roles and Responsibilities around MCA / DoLS Guidance?
- Does the service or activity have a quality assurance framework and service standards which explicitly include the MCA?
- Are there clear expectations and reporting requirements in relation to the MCA?
- Are the duties of commissioners and providers clear in relation to the MCA and evidenced and is the Court of Protection used as the final stage in settling disputes?
- Does Commissioning and contracting with regulated providers include Care Quality Commission (CQC) registration guidance in relation to MCA/DoLS?
- Does contract monitoring have a focus on MCA compliance and on the application of the DoLS including monitoring compliance with conditions and addressing any shortfalls?
- What data is being gathered re MCA /DoLS and where is it shared?
- Do tender documents and processes make it clear that the MCA principles must be embedded across the services provided?
- Do contracts require compliance with the MCA including where appropriate the DoLS?
- Do commissioners expect and monitor compliance with the MCA?
- Do commissioned services all include statements that they promote and work within the MCA guiding principles?
- Are job descriptions clear about expectations of staff roles in relation to the MCA?
- Rather than policies ‘on’ the MCA, is the MCA a feature in every policy and procedure of the ICB/provider organisations?
- Is the wellbeing principle evident throughout the consultation, planning, procurement and monitoring of service delivery?

MCA Quality Assurance Framework

The following questions adapted from the ADASS Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance can be utilised by commissioners and providers to promote the Mental Capacity Act and to assure themselves they are commissioning/promoting compliance

Questions are broken down via the 5 Principles

1. An assumption of capacity

- Is the assumption of capacity clear in the service's ethos and practice?
- Are people treated as autonomous individuals and is this clear throughout the service?
- Are the rights of people who use the services protected?
- Does the service aim to enable and empower, or is the emphasis on protection and paternalism?
- Does the service provider have an understanding of when it is necessary to assess a person's capacity?
- Do the paperwork and processes reflect a difference between day-to-day decision
- making and complex decision making?
- Does the service and its managers demonstrate an understanding of when a formal assessment is needed and how to record it?
- Does the organisation offer choice which is real and valid?
- Is there a person-centred approach to personal care, food, social activities?
- Is the organisation clear when a person has the right to say 'no' and when this may arise from a lack of capacity?
- Can the organisation demonstrate person centred care planning?
- Does the organisation understand and practise an approach to safeguarding which is person centred and avoids unnecessary risk-aversion?
- Are staff trained and able to apply the principles of the MCA?
- Is MCA compliant practice an integral part of staff supervision, mentoring and evaluation?
- Does the service provider's training, induction and refresher training policy include the MCA?
- Does the service provider's staff induction include the MCA?
- Are there arrangements in place to ensure MCA-related case law is explained to staff; and evidence that staff are familiar with the Code of Practice and have easy access to it when seeking guidance?
- Is the assumption of capacity evident on admission and throughout consideration of deprivation of liberty

MCA Quality Assurance Framework

The following questions adapted from the ADASS Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance can be utilised by commissioners and providers to promote the Mental Capacity Act and to assure themselves they are commissioning/promoting compliance Questions are broken down via the 5 Principles	
2. Supported decision making	**3. Unwise decision making**
• Does the organisation have a clear commitment to enhancing communication? • Is an appropriate level of detail kept in relation to a person's communication needs? • Are basic matters such as wearing of hearing aids and glasses by those who need them, given prominence? • Is the organisation aware how to contact interpreters including sign language and languages other than English if they are needed? • Are there a variety of communication methods available for staff to use to enhance communication? • Are people given the right information, at the right time, in the right way to enhance their ability to make their own decisions? • Are risk assessments and care plans regularly reviewed allowing for the person's learning and development, together with as much freedom as possible? • Is appropriate staff time allowed to support informed decision making? • Is there an ethos to support decision making rather than one which seeks to impose decisions for people? • Are staff appropriately trained to communicate with people who may have difficulty communicating	• Does the organisation recognise that a person cannot be deemed to lack capacity simply because of an unwise decision? • Is there an ethos which allows for, and accepts some element of risk in order to promote autonomy? • Are people encouraged to reflect on their actions with the support of staff? • Is the organisation flexible enough to adapt to a range of different decision making abilities? • Are staff trained to recognise the inherent rights and value of all people whether they have a disability or not? • Do staff understand their role in supporting decision making and not overruling a person's choice? • Are behavioural techniques and other forms of restraint MCA compliant and is their use regularly reviewed?

MCA Quality Assurance Framework

The following questions adapted from the ADASS Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance can be utilised by commissioners and providers to promote the Mental Capacity Act and to assure themselves they are commissioning/promoting compliance

Questions are broken down via the 5 Principles

4. Acting in the person's best interests	5. Less restrictive option
• Is there plainly a culture which clearly promotes autonomy and choice but recognises when decisions must be made for others? • Does the service ensure staff fully understand and apply the best interests decision making principles? • Is there evidence to clearly demonstrate that the statutory checklist for best interests decision making is followed when necessary? • Is the service, its managers and staff able to demonstrate how people are involved in all decisions about them, whether they have capacity or not? • Is the service able to demonstrate that appropriate consultation (principally with relatives or friends) is always carried out when making best interest decisions? • Is the service able to show how people participate in decisions about them? • Is it clear from recorded decisions what the person's wishes, feeling beliefs and values were and whether they could be adhered to or not? • Are decision makers clearly identified with an appropriate level of responsibility? • Is there evidence of the use of a balance sheet approach for complex decisions? • Have staff received training in best interests decision making and is the learning embedded through one to one sessions, mentoring and other methods of staff support? • Does the service have a clear, MCA compliant policy in relation to Do Not Attempt Cardiopulmonary Resuscitation DNACPR decision making? • Is the right to liberty, privacy and family life reflected in care planning and in best interests decisions made on behalf of those lacking capacity? • Are providers aware when a restriction of liberty may become a deprivation of liberty and do they know how this should be authorised?	• Does the service have a statement in relation to people's human rights? • Does the service ensure its staff are trained in Human Rights Act, MCA and how to recognise deprivation of liberty? • Is there a clear policy in relation to restraint which is MCA compliant? • Can the service ensure it protects rights and balances protection but with appropriate use of restraint where necessary? • Does the service have a clear understanding of everything that may amount to restraint including chemical restraint, diversion and dissuasion, physical restraint such as mats and lap belts, monitoring devices such as sensors, and locked doors to restrict freedom of movement? • Are risk assessments clearly documented and regularly reviewed and updated? • Is the service able to demonstrate an understanding of the difference between restriction and deprivation of liberty? • Does the service have a clear policy that restrictions are regularly reviewed to assess if they can be lessened, prior to making an application for a DoLS authorisation? • Are staffing levels appropriate to avoid unnecessary monitoring? • Are all staff trained in appropriate restraint techniques at a level appropriate to their role? • Is there a person centred approach to care which provides a rationale for every restriction in place e.g. why a door is locked, why a person has 2:1 support? • Is there an ethos within the service which endeavours to reduce all restrictions in place and promote liberty, autonomy and wellbeing?

MCA Quality Assurance Framework

The following questions adapted from the ADASS Putting the Mental Capacity Act principles at the heart of adult social care commissioning: A guide for compliance can be utilised by commissioners and providers to promote the Mental Capacity Act and to assure themselves they are commissioning/promoting compliance Additional Questions
Lasting Power of Attorney (LPA) and deputies
• Does the service promote the making of LPAs whilst people aged 18 or over still have capacity? • Does the service collect information in relation to decision making, such as who has an LPA or Deputy? • Does the service ensure that even where an LPA or Deputy exists people are supported to make decisions they have capacity to make? • Are managers aware of the route to challenge the conduct of an LPA or Deputy? • Are all staff aware of the limitations of the power of an LPA or Deputy? • Is there evidence that the validity of LPAs are checked by staff to confirm their validity?
Advance Decisions to Refuse Treatment
• Does the service promote the use of Advance Decision making for people who have capacity? • Do the service, its managers and staff have a clear understanding of the application and limitations of advance decision making? • Does the recording within the service highlight where Advance Decisions have been made? • Is the DNACPR policy compliant with the MCA requirements for advance decision making?
Independent Mental Capacity Advocate (IMCA)
• All commissioners and providers of services to people aged 16 or over must be aware of the role and remit of the IMCA service. • Can the service demonstrate clear policies and procedures in relation to IMCAs? • Are staff aware of the mandatory referral requirements and as such are they able to alert the professionals who need to make the referral? • Are IMCAs considered through the safeguarding adult process where they would be of benefit to a person who lacks capacity in relation to their engagement and involvement with the process?

Tools to support implementation of the MCA Quality Assurance Framework

Audits	Policies and Good Practice Guidance
Lancashire SAB MCA Audit Tool RCGP MCA Audit tool for GPs Further audit templates (you must be a member of the Future NHS Platform to access)	Lancashire SAB Sample Provider policy Lancashire SAB Sample Covert Medication Guidance OPG : Making decisions: a guide for people who work in health and social care The Royal College of Emergency Medicine MCA Good Practice Guidance Further templates (you must be a member of the Future NHS Platform to access)
Forms	**Training**
Kent county council MCA Forms COP 3 Form (ADASS Good Practice Guide to complete) Further form templates (you must be a member of the Future NHS Platform to access)	Mental Capacity Act - eLearning for healthcare (e-lfh.org.uk) Mental Capacity Act (MCA) training courses | SCIE Mental Capacity Toolkit Further training examples (you must be a member of the Future NHS Platform to access)

Additional Tools

The NICE Decision Making and Mental Capacity Audit and Service Improvement Template can be utilised to establish clear quality standards/expectations within an organisation around MCA

Pan-London NHS: MCA lead toolkit **: A series of resources developed to support awareness and compliance.**

SCIE MCA Directory The MCA (Mental Capacity Act) Directory has been developed to provide a single space for the sharing of useful information and tools to aid the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards. Here you will find publications, videos, and academic research that professionals across Health and Social Care may find useful in their day-to-day practice**.**

ADASS Mental capacity act including the deprivation of liberty safeguards: An improvement tool

Additional Resources

Mental Capacity Act Specific Guidance and Tools

- The Mental Capacity Act Toolkit.

  Mental Capacity Act Code of Practice
- British Medical Association, Best interest's decision-making for adults who lack capacity :A toolkit for doctors working in England and Wales
- 39 Essex St: Mental Capacity Guidance Notes
- Capacity Guide: Guidance for clinicians and social care professionals on the assessment of capacity
- British Psychological Society: Supporting people who lack mental capacity - a guide to best interests decision making
- British Psychological Society :What makes a good assessment of capacity?
- NICE: Decision-making and mental capacity: Implementation resource to help you put the NICE guideline into practice
- Edge Training MCA Resources

Mental Capacity Act Specific Videos

- SCIE: Using the MCA
- HRCH: Using the Mental Capacity Act in the community
- Worcestershire Safeguarding Adults Board Executive Function
- HRCH Capacity Coach videos. Introduction , Decision-making & When capacity is complicated
- MCA Project Videos
- National Mental Capacity Forum Videos and Webinars
- Bevan Britton Practical and Legal Guidance for Assessing Capacity

Deprivation of Liberty Safeguards

- DHSC Deprivation of liberty safeguards: resources
- SCIE Deprivation of Liberty Safeguards (DoLS) at a glance
- The Law Society, Deprivation of liberty safeguards: a practical guide
- MIDNIGHT LAW: Deprivation of Liberty In Intensive Care
- LGA: Mental Capacity Act including DoLS and LPS Guide
- RiP Practice Guidance: Deprivation of Liberty and 16-17 year olds and "Shedinar" (33 mins)
- 39 Essex Chambers: Deprivation Of Liberty In The Hospital Setting
- A basic guide to the Court of Protection
- The Law Society: Quick reference guide to identifying a deprivation of liberty in the supported living setting
- The Law Society: Quick reference guide to identifying a deprivation of liberty in the home setting
- BMA Deprivation of Liberty Safeguards Guidance
- Edge Training DoLS Resources