HM Government

National Mental Capacity Forum

Chair’s Annual Report 2020 – 2021

Feburary 2022

Fifth Annual Report of the National Mental Capacity Forum

Table of Contents

Fifth Annual Report of the National Mental Capacity Forum

Executive Summary

My annual report for 2019/20 was published in August 2020 and set out how the work of the National Mental Capacity Forum had been diverted during the year almost entirely to responding to issues arising from the unprecedented COVID-19 pandemic.

At the time of writing my last report we had held three COVID-19 rapid response webinars, covering the most urgent issues arising for people with lived experience of mental capacity issues and the professionals working with them. Those challenges were primarily around undertaking capacity assessments when face to face contact was not possible; concerns for the mental health of people who were separated from their close friends and family by pandemic restrictions; and also the toll of the pressures on front-line staff and families working to make the quality of life as good as possible for those for whom they cared and had responsibility.

I said in my last report that I wanted to build on the success of these webinars, which reached far more people than our earlier face-to-face Action Days had been able to (and at relatively low cost for both organisers and participants). And it is my belief that we have continued to expand the reach and effectiveness of the Forum through these new ways of working over the last year.

COVID-19 has continued to be the main focus of the Forum’s work over the period that this report covers, from summer 2020 to summer 2021, with the webinars focusing on taking stock of current issues at various points in the pandemic, vaccination and best interests decisions. We have ensured the continued relevance of the webinars by seeking participants’ views on what it would be most helpful to cover in terms of the problems they were experiencing and solutions they had found.

The Forum has also in recent months started to consider wider mental capacity issues again, for instance the transition from childhood to adulthood and what that means for young people.

I am indebted to everyone who has supported me in planning and running the webinars, particularly Professor Wayne Martin from the Essex Autonomy Project at the University of Essex, and Alex Ruck Keene of 39 Essex Chambers. And of course to everyone who has participated in the events, submitted their ideas, and, most importantly, disseminated good practice.

I said last year that the warm human concern and creativity demonstrated in the pandemic had been wonderful and must not be lost as we move out of the pandemic. I have continued to be struck by those threads running through all of the Forum's activities this year, and people's determination to make services as focused as possible on the needs of individuals in these testing times.

Baroness Ilora Finlay of Llandaff

January 2022

1. The Mental Capacity Act and the COVID-19 pandemic

Early work by the National Mental Capacity Forum in the COVID-19 pandemic

During the early months of the COVID-19 pandemic in spring 2020 the National Mental Capacity Forum received an increasing number of queries and concerns about the risks to those with impaired capacity and to those providing care, both in people's own homes and in residential care homes. Particular concerns related to Deprivation of Liberty Safeguards (DoLS) assessments and how the principles of the Mental Capacity Act 2005 (MCA) would be upheld in the face of the Coronavirus Act 2020[1].

Despite attempts to rapidly disseminate the message across the health and social care sectors that the MCA was still in place and not eroded by the Coronavirus Act 2020, it became clear that more was needed. The Forum's 'rapid response' webinars presented an opportunity to address the issues associated with the MCA and the pandemic.

As reported in the NMCF Chair's Annual Report 2019-2020[2], the Forum initially held three webinars. These proved to be a success, allowing the Forum to welcome up to 500 participants to each. Feedback from participants was overwhelmingly positive, and there was a clear desire for further webinars.

Building on the success of the earlier webinars, the Forum launched a further series in 2020-2021, dealing with emerging issues in the rapidly changing landscape of the pandemic. The webinars have successfully brought together many professionals from across England and Wales and provided a new symposium for information to be shared. The individual webinars, starting in September 2020, are described below.

Key issues over the last year

Rise in deaths in those with learning difficulties

Concerns of a high death rate in those with learning difficulties was confirmed by a Care Quality Commission (CQC) report published on 2 June 2020. The report looked at all deaths notified to CQC between 10 April and 15 May from providers registered with CQC who provide care to people with a learning disability and/or autism (including providers of adult social care, independent hospitals and in the community), and where the person who died was indicated to have a learning disability on the death notification form[3].

CQC found that from 10 April to 15 May 2020 there was a 134% increase in death notifications (386 deaths compared with 165 in this period in 2019). The majority of these deaths (206) related to suspected or confirmed COVID-19.

Distance aware

At the beginning of March 2020, the concept of 'social distancing' became a prominent feature of public health advice, with a requirement to keep two metres from others in any public spaces. On 10 March hospitality and indoor leisure facilities were forced to close, and people were urged to stay home and avoid non-essential travel.

Anecdotal reports emerged of people with impaired capacity being shouted at by others when they failed to understand and obey the new rules, such as going into shops without queueing.

---

[1] Coronavirus Act 2020
[2] NMCF Chair's Annual Report 2019-20
[3] CQC report on deaths of people with a learning disability

Those who were shielding were often acutely aware of the risk to themselves and felt particularly anxious about public spaces. In Wales, the Distance Aware campaign[4] was introduced to promote the need for ongoing social distancing. The campaign developed a simple shield logo which could be worn on a badge or lanyard to let people around you know that you were social distancing. This was developed through the Bevan Commission in Wales with support of the Welsh Government. The shield logo was available in a range of colours to maximise inclusivity, and specific colour schemes were developed for people with autism, visual impairment, or dementia. Badge makers donated 130,000 badges to NHS Wales and the project was subsequently adopted by the Department of Health in Northern Ireland, where it was formally launched in August 2020.

As people emerge from lockdown in 2021, it has become clear that many people living with dementia have lost confidence in going out and in how to navigate public places. Many people with dementia have comorbidities which make them particularly vulnerable to COVID-19, but maintaining a routine and being able to participate in activities is vital to their wellbeing. In Wales, the Getting There Together campaign[5] was developed to support people with dementia in different communities rehabilitate to increased levels of activity. NHS Wales produced a series of videos to prepare people for reintegrating into the community and to provide them with support.

2. The 2020-2021 ’Rapid Response’ Webinars

Each webinar was advertised thorough the NMCF’s network of contacts that had been built up over previous years. Upon registering for each webinar, attendees were asked to complete a short questionnaire about current issues of concern to them. These were analysed by Professor Wayne Martin and Dr Emily Fitton at the Essex Autonomy Project (University of Essex). The process ensured a dynamic iterative dialogue with those working across England and Wales, with first-hand experience of current and emerging problems.

Each webinar was attended by a minimum of 300 people. The webinars were open for anyone to register to attend but were consistently attended by professionals from across the health and social care sectors including the NHS, local authorities and social care providers, community and voluntary organisations and legal services. The webinars were each about an hour long and sought to deal with the most topical issues that were emerging as concerns at the time of the pandemic. Each webinar contained a series of short presentations from people working in the relevant field, with the content designed to ensure that attendees’ feedback was listened to and acted on. Each presentation aimed to empower attendees to find their own solutions to local problems and difficulties they encountered, while assuring attendees that they were not alone as they tried to find their way through the different pieces of guidance and information in a situation that none of us had encountered before

The webinars also aimed to provide emotional and moral support to attendees, recognising the challenging circumstances they were working in, and acknowledging the difficulties they were encountering in their roles.

The **Appendix** to this document summarises participants’ responses to the questions they were asked as part of the registration process, relating to their experiences during the pandemic.

---

[4] Distance Aware campaign
[5] Getting There Together campaign

Each webinar was recorded and then posted along with the accompanying presentation slides on the Essex Autonomy Project website[6] and the SCIE National Mental Capacity Forum website[7]. Since September 2020, there have been five webinars organised. See the 2019/20 annual report[8] for details of the first three webinar events.

Taking stock and looking forward – the fourth webinar

The fourth webinar took place on 9 September 2020, titled 'Taking stock and looking forward'[9].

Those who registered to attend the webinar were asked:

- What key mental capacity issues must be addressed for ongoing and future COVID-19 management?
- From your experience, what lessons about the Deprivation of Liberty Safeguards (DoLS) in the pandemic should be incorporated in the new Liberty Protection Safeguards (LPS), when they replace DoLS?
- Drawing on your experience of the pandemic, which issues need additional guidance in the revised MCA Code of Practice?

Responses were analysed by Professor Wayne Martin and Dr Emily Fitton.

It was clear that by September 2020 there was some optimism that the situation may be improving and that a period of consolidation was now needed. Concerns over items such as PPE had lessened. However, respondents did not feel that the MCA was operating as well as it had done before the pandemic and raised a number of issues around its application.

Concerns around remote assessments persisted. Respondents felt that staff would benefit from more training on how to conduct remote assessments effectively, and the need for better technology to enable them to do so. They also identified a need for clear best practice guidance on when and how remote assessments could or should happen.

Respondents believed there was a need to improve awareness of the second principle of the MCA, namely ensuring that all practicable steps were taken to support the person to make their own decisions before concluding that the person lacked capacity. There were also concerns around best interests decision-making and the need to consult with those who know the person well, which became more difficult in the absence of face-to-face contact.

The tension between public health and deprivation of liberty was highlighted as a key issue. This was particularly evident in scenarios where it was necessary for someone infected with coronavirus to be isolated in order to protect others.

Respondents continued to express concerns over the wellbeing of those who were unable to receive visits from their family, and isolation was reported as causing a disproportionate decline in the health of those with dementia.

Respondents shared a number of suggestions for lessons about Deprivation of Liberty Safeguards (DoLS) in the pandemic that they felt should be incorporated in the new Liberty Protection Safeguards (LPS). This included the need for simpler paperwork and improved systems to allow for the transfer of

---

[6] Rapid Response Webinars - Essex Autonomy Project

[7] Coronavirus (COVID-19) webinars | National Mental Capacity Forum (scie.org.uk)

[8] NMCF Chair's Annual Report 2019-20

[9] Webinar recording: Taking stock and moving forward

documentation. Respondents also called for clear and concise guidance on ‘how to avoid restrictive practices’, and clarification on the legality of restrictions imposed for public health reasons.

It was felt that remote or equivalent assessments should continue in some scenarios, but that practitioners should return to using face-to-face assessments where remote assessments were not appropriate. Again, respondents identified a need for further training and best practice guidance on how best to use different types of assessment.

Those involved in presenting were:

Claire Webster - North Yorkshire County Council

Yvonne Phillips - Adult Social Care and Health Kent County Council

Hanna Gottschling - London Borough of Sutton

Dr Clementine Maddock - Priory Group Ty Catrin

Professor Claire de Than - University of London and Jersey Law Commission

Catherine Lawlor - Wokingham Community Hospital

Kate Mercer – Kate Mercer Training

Michelle Moore - Sandwell and West Birmingham CCG

Stef Lunn - Practice Consultant, England & Wales

Lyz Hawkes - POhWER

Kam Padda – Wokingham Borough Council

Lorraine Currie – Shropshire Council

Duc Tran – Bournemouth, Christchurch and Poole Council

Scott Watkin – Learning Disability England

Dr Lucy Series – Cardiff School of Law

Alex Ruck Keene – 39 Essex Chambers

MCA and the messy reality of COVID-19 - the fifth webinar

The fifth webinar took place on 11 November 2020, titled **‘MCA and the messy reality of COVID-19’**[10]. Those who registered to attend were asked to complete a pre-registration survey which contained a number of questions about:

- ‘Do Not Attempt Cardio-Pulmonary Resuscitation’ (DNACPR) orders
- Department of Health and Social Care (DHSC) guidance on visits to care homes during the pandemic
- the transition from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS), and what Government should focus on in preparing for this transition.

By November there was increasing media coverage of the DNACPR (sometimes wrongly referred to as DNAR) notices that had been issued. The webinar sought to address issues of consent surrounding the

---

[10] Webinar: MCA and the Messy Reality of COVID-19

use of DNACPR and raise awareness of the requirements of the ‘Montgomery test’, for example the need to provide patients with adequate information in order to exercise informed consent.

The webinar highlighted that consent to a DNACPR must be obtained from the person to whom it applies. Where that person lacks capacity, the decision to withhold attempting cardiopulmonary resuscitation in the event of a cardiac arrest can only be taken after a proper best interests decision-making process, in line with the MCA.

The reality of such difficult decisions was brought home forcibly by personal stories from the mother of a child with learning difficulties and a wife’s description of her desperately ill husband.

The pressures experienced by emergency departments were also graphically described, along with the benefit of having an ‘MCA champion’ on every ward in a hospital. The learning in busy acute units was evident, with rapid expansion of bed space and the ability to take in large numbers of acutely ill patients, where training for continuous positive pressure ventilation had to be rolled out in days. During the preceding months increases had been seen in acute mental health problems and domestic violence, and yet during all this time staff had tried hard to ensure all patients were being treated as if they were a member of their own family.

This webinar demonstrated clearly that long term planning of more acute care capacity would be needed in the future because the acutely seriously ill cannot be cared for in the community.

The preparations for training the workforce were seen to be urgent if the target implementation date for the introduction of LPS was to be met. This was being planned through awareness-raising across all sectors, increasing competencies in those who encounter deprivations of liberty, and upskilling the competency groups that undertake assessments, authorisation roles, advocates, and other professional roles. The current Best Interest Assessors also needed training to transition to the new roles of Approved Mental Capacity Assessors.

The relaxation in care home visiting restrictions, dated from 5 November 2020, was also announced at this webinar. This was welcome news to many members of the Forum.

Those involved in presenting were:

Prof Irene Tuffrey-Wijne - Faculty of Health, Social Care & Education Kingston University and St. George’s, University of London

Dr Jonathan Martin - Consultant in Palliative Medicine, London

Chloe Cameron – West Hertfordshire Hospitals NHS Trust

Betsey Lau-Robinson - University College London Hospitals NHS Foundation Trust

Hilary Paxton - Association of Directors of Adult Social Services (ADASS)

The MCA and COVID-19 vaccinations in care homes – the sixth webinar

The sixth webinar took place on 18 December 2020, titled **‘MCA and COVID-19 vaccinations in care homes’**[11].

---

[11] MCA and Covid-19 vaccinations in care homes

The registration capacity of the webinar was increased from 500 to 1000, and over 1000 people registered to attend. Those who registered to attend completed a short survey which asked a number of questions about issues surrounding consent, capacity, and best interests in the context of COVID-19 vaccinations.

Responses revealed a number of concerns relating to coronavirus vaccinations. In particular, respondents shared concerns about how the roll-out of vaccinations would work in care homes, and about how to obtain consent to vaccinate adults who lack capacity to consent to being vaccinated themselves.

Responses to the questions also demonstrated some clear gaps in knowledge and understanding of issues relating to consent and capacity. Despite this being a highly motivated audience, approximately one fifth of respondents did not know how to check the validity of a Lasting Power of Attorney (LPA) and under half of the respondents were confident they understood the role of a Court Appointed Deputy. Similarly, around a fifth of respondents did not know where to find official guidance on vaccinations, and half of all respondents thought that consent always had to be in writing, whereas the process of consent with information giving and answering questions is the core of the process to obtain consent. This highlighted the need for the Office of the Public Guardian to mount an awareness raising campaign of LPAs and deputyships.

The webinar aimed to tackle the concerns around vaccination roll-out that were raised by respondents via the registration questions, and to share real-life experiences from GPs who had been involved in the early pilots of the vaccine roll-out. The advice was very practical, including a checklist of equipment needed for planning a vaccination session, and how to assess capacity for consent to vaccinate.

The webinar also suggested ways that disputes over vaccination could be tackled. To help with staff education, Essex Chambers through Alex Ruck Keene produced a rapid response guidance note on vaccination and mental capacity[12].

Those involved in presenting were:

Dr Bryony Kendall – Aintree PCN, Liverpool

Dr Elisabeth Alton – North.Lincolnshire and East Riding of Yorkshire CCG

Patricia Winchester – My Voice, Jersey

Alex Ruck Keene – 39 Essex Chambers

Christine Whiteside – Care home, Wales

Best interests decisions: supporting primary care in difficult times – the seventh webinar

The seventh webinar took place on 21 January 2021, titled '**Best interests decisions: supporting primary care in difficult times'**[13]. As previously, those who registered to attend completed a short survey ahead of attending the webinar which asked questions about:

- Confidence in applying the MCA
- Steps in best interests decision-making
- Best interests as a medical question

---

[12] Rapid response guidance note: vaccination and mental capacity
[13] Best interests decisions: supporting primary care in difficult times

- Best interests as a subjective question
- The most difficult aspects of best interests assessments

The previous webinars had repeatedly revealed a lack of understanding of best interests decision-making or concerns about how best interests decisions were reached by others. Responses to the registration questions confirmed that the lack of face to face contact was making the process more difficult and therefore at risk of being less reliable.

The webinar

The aim of the webinar was to share knowledge, to reinforce good practice, and to empower primary carers to have meaningful engagement about admission and advance care planning with patients who may lack capacity.

This webinar tackled the issue of best interests decision-making in the context of the national campaign to roll out the COVID-19 vaccination programme as soon as possible. It also tackled the need to be prudent in what is provided, emphasised that harm must be avoided and that good communication, including careful listening to concerns and perceptions, underpins joint decision making.

The role of regulation, as exercised through the Care Quality Commission (CQC), also addressed the practical changes required through the use of remote assessments in practice.

Those involved in presenting were:

Dr Karen Chumbley – Lead for End of Life Care, North East Essex Health and Wellbeing Alliance

Alex Ruck Keene – 39 Essex Chambers

Dr Tim Ballard – Care Quality Commission

Dr Bryony Kendall – Aintree Primary Care Network

Dr Elisabeth Alton – North.Lincolnshire and East Riding of Yorkshire CCG

The MCA and COVID-19: the good, the bad and the ugly – the eighth webinar

The eighth webinar took place on 22 March 2021, titled **'The MCA and COVID-19: the good, the bad and the ugly'**[14]. Those who registered answered questions about visiting restrictions in care homes and the transition from childhood into adulthood for persons with impaired decision-making capacity.

Most registrants reported changes in visiting restrictions in care homes. These included the establishment of a regular routine of testing for visitors, the introduction of new secure locations for visiting, and a general easing of restrictions. One third of respondents reported that a 'no visiting' policy was still in place.

Respondents shared a number of challenges faced by those who lack capacity and are navigating the transition between childhood and adulthood. These included a lack of understanding of the MCA and DoLS, challenges associated with gaining independence from parents, and the transition to adult services.

---

[14] The MCA and Covid-19: the good, the bad and the ugly

Respondents also suggested changes that could be introduced to make this transition easier such as planning ahead, better cooperation between children and adult services, and the allocation of named key workers.

Of great concern was that almost one fifth of respondents reported a ‘spill over’ from DNACPR decisions to adversely influence other medical decisions during the pandemic.

The focus of this webinar moved away from those residing in care homes, many of whom are elderly and living with varying degrees of dementia and focussed instead on young adults with impaired capacity. Specifically, the webinar focused on the transition from childhood to adulthood experienced by young adults from their 18th birthday onwards, and the difficulties faced by parents and other family members during this period of transition. The webinar shared examples of the difficult situations which some families faced, including a family who were suddenly without help in caring for their child with severe learning difficulties, as the child was legally an adult. This case was described by the mother of two young people with learning difficulties and the legal aspects of provision were clarified by HH Senior Judge Hilder from the Court of Protection.

<u>Those involved in presenting were:</u>

Margot Kuylen - The Essex Autonomy Project

Alex Ruck Keene – 39 Essex Chambers

HHJ Carolyn Hilder – Court of Protection

Isobel Vass - Parent of adult children with learning difficulties

Vivienne Harpwood – Chair of Powys Health Board & Prof of Law Cardiff University

Mario Kleft – Care Forum Wales

Approaching the cliff edge of 18 – the ninth webinar

The ninth webinar took place on 15 June 2021, titled **‘Approaching the cliff edge of 18’**[15]. Those who registered to attend the webinar were asked the following two questions:

- In your experience, what are the three main issues of concern relating to young people with capacity impairments approaching their 18th birthday?
- I am interested in attending this webinar primarily in my role (tick all that apply):
    - as a professional
    - as a parent
    - as a young person approaching 18
    - other

Questions tabled in Parliament about Child Trust Funds that mature on a person’s 18th birthday had revealed a lack of preparation amongst families and services for the time when a young person turns 18 and there is a change in their legal status. The ninth webinar sought to address the challenges faced by young adults and their families during the transition from childhood to adulthood. This webinar was the first event that was not directly linked to the pandemic.

Those who registered to attend the webinar were predominantly those with professional responsibilities, but the webinar was also attended by some parents.

---

[15] Approaching the cliff edge of 18

The registrants highlighted the poor understanding of the MCA amongst children's services, the great difficulty parents experience when they discover they no longer have parental responsibility for decision making and consent when their child turns 18, and that some services are poorly equipped to support young adults in decision-making. All this is made more difficult by children's services then transferring the person to adult services, which often have a different philosophical approach to the person and family. The complex co-morbidities of many of these young people means that they are usually referred to several different adult services, whereas up until the point of transfer they had been under the care of a designated paediatric service. The difficulties for these young people range across a very wide spectrum from mild autism to profound learning difficulties with complex physical health problems. This underlines the need for individualised planning. Examples of good practice were used to illustrate this. But it was acknowledged that difficulties encountered are compounded by poor communication between services.

A myth busting guide was also produced and launched at this webinar, to help parents and staff plan together well before the age of majority is reached, with the aim of avoiding some of the problems some parents have encountered.

<u>Those involved in presenting were:</u>

Ilora Finlay – Chair of the National Mental Capacity Forum

Alex Ruck-Keene – 39 Essex Chambers

Tim Nicholls – National Autistic Society

Professor Irene Tuffrey-Wijne – Kingston University & St George's, University of London

Dr Jo Elverson – St Oswald's Hospice and Great North Children's Hospital

Martin Sexton – Salford Council

Suzanne Jankowski – Salford Council

Rachel Taylor – Hope House, Ty Gobaith (Children Hospices)

Caroline Bielanska – Consultant

3. Conclusions and next steps

These webinars have revealed several issues that will inform the work of the Forum in the coming months:

- Staff across sectors showed great creativity in the face of the national emergency of the pandemic. This creative energy should be encouraged and nurtured, not supressed by a drifting return to normal.
- Staff tried to take a very person-centred approach, sometimes with little support or guidance. Again, such initiatives in the interests of the population they serve should be encouraged if adverse unintended outcomes are to be avoided.
- Those creating regulations for public health must recognise the unique and deep trauma experienced by the vast majority of relatives when separated from the person they love at a time of life-threatening illness and when dying.
- Staff resilience must not be exploited or presumed to be infinite as staff stress is evident.

- Managers need to take a flexible and supportive approach to workplace duties, rotas etc for those with caring responsibilities at home, whether caring for children or for seriously ill older family members.

- The shortage of acute care beds in the NHS needs to be addressed urgently, with far greater integration of care pathways into the health treatment pathways to ensure patient flows are appropriate to clinical need and clinical service pressures.

- Community services need urgent attention to provide 24/7 support for families with a person with severe learning difficulties, as currently both the appropriate health and social care services are relatively unavailable for 75% of the week's hours, often being unavailable at a time of crisis.

- The use of decisions such as DNACPR needs careful auditing to ensure decisions are based solely on what is best for the individual and are not driven by economic expediency.

- Preparation for transition from childhood to adulthood needs to be tackled at a national level. One route would be to work with the Department for Education to encourage all schools to provide the parents/ guardians of young people aged 15-17 with any degree of learning difficulty with information about preparing for legal adulthood, for example by supporting the young person to consider lasting powers of attorney to people whom they trust to always work in their best interests.

- Paediatric and child health services need to consider the MCA more in their everyday practice.

- Those caring in any capacity for a person with impaired mental capacity need to pay specific attention to supporting the person to make their own decisions.

- Tools such as 'Books Beyond Words' can be useful aids to supported decision-making but need far greater publicity amongst services.

- The transition from DoLS to LPS will require increased support to all services.

- Great care needs to be taken to avoid LPS becoming a bureaucratic burdensome procedure with little benefit to the individual.

During the pandemic other factors were thrown into sharp relief, which require a small investment. They would avoid greatly increased expenditure in the future and would reap great rewards for those affected by the Mental Capacity Act. These should be considered clear 'invest to save' initiatives:

- The Court of Protection urgently needs a modernised IT system that can cope with the workload, allow tracking of cases and ensure information is generated through proper system reports. During the pandemic the Court managed to continue to function remotely, but the absence of a modern IT system meant that paper files had to be couriered out to judiciary and court staff who were working from home. This was an avoidable expense, created potential security risks as these files contain highly confidential information, and meant that tracking of work was made more difficult. It is to the credit of the Court staff that they managed to maintain a service during lockdown, but the situation needs urgent attention with a modernised information system in place and overall computer upgrades.

- The Office of the Public Guardian needs to ensure that all those appointed to hold a Lasting Power of Attorney (LPA) are appraised of their duties to support the person for who they make decisions, and that their responsibilities only take legal force for making a decision on behalf of the person, when the person (donor of the LPA) lacks capacity for that particular decision (unless otherwise specified in the LPA). The donee (holder of the LPA) must undertake a best interests process and ensure that all decisions are taken solely in the best interests of the person who lacks capacity, and not in the interest of others.

- All involved in providing services to others need core mandatory training in the five principles of the MCA, and in awareness of pointers to abuse, particularly domestic abuse. Staff and volunteers alike need to know who to contact if they have concerns and need to know that their concerns will be heeded with sensitivity and confidentiality observed as appropriate.

- The Government - needs to provide straightforward guidance to Special Educational Needs staff in all sectors to prepare parents and guardians for the watershed of age 18, where the legal status of the person changes from ‘child’ to ‘adult’. This should include encouraging parents and guardians to take early action to consider whether the young person has capacity to appoint their own LPA, or whether the Court of Protection will need to be involved. Failure to establish legal protection for the young person via one of these two routes leaves them particularly vulnerable in emergency situations, both for decisions relating to their health and welfare, and for financial decisions.

Finally, I would like to thank all those staff across the country who worked so hard during the pandemic, going above and beyond their usual roles. I wish to thank Alex Ruck Keene and Professor Wayne Martin in particular because without their constant input and support the series of webinars would not have been possible and I am most grateful to the officials at the Ministry of Justice and Department of Health and Social Care for their supportive action whenever issues have been raised with them.

4. Appendix

National Mental Capacity Forum Webinars

Registration Data Summary

Background

Beginning in April 2020, the National Mental Capacity Forum held a series of webinars as part of its response to the COVID-19 pandemic. The webinars were chaired by Baroness Finlay and hosted by the research team of the Autonomy Project at the University of Essex. As part of the registration process, participants were asked a number of questions relating to their experiences during the pandemic. This document summarises their responses.

Webinar 1 – April 1st, 2020

Sharing Voices in Response to COVID-19

Registrants were prompted with the following question:

1.What are the big issues affecting you in the context of the pandemic?

Responses from registrants: [16]

<u>Theme</u>	<u>Issues Identified by registrants</u>
<u>Access and assessments</u>	• Capacity assessments/best interests involvement of P • Advocates accessing people • Assessing via video link • To undertake MCA over the phone • Obtaining instructions from my clients, organising court hearings • Access to money and specific capacity assessments • Face to face contact with P • How to conduct MCA assessments without face to face contact • DoLS assessments • Time to complete assessments of capacity assessments, patients refusing entry to professionals, care homes closed, staff anxiety • Delivering effective MCA/DoLS training to health & social care workers • How do we robustly assess capacity when minimal visits are occurring? Concerns regarding care homes closing to visitors • Lack of face to face contact • How to carry out MCAs, DoLS assessments etc creatively and not face to face? • Care home access, suspension of DOLS, people unable to undertake capacity assessments face to face • Not being able to complete DoLS assessments and assess individuals face to face to hear their views etc. • Completing MCA whilst following government guidelines. • DoLS, MCA, health not knowing DoLS or MCA well whilst being charged with being the people most appropriate to do assessments • Staff shortages, increased demand. DoLS backlogs and impossibility of full legal compliance. Guidance for acceptable practice.

---

[16] This table contains the responses of the first 350 registrants. Registrant responses are given in the right-hand column, and have been sorted according to theme, which is given in the left-hand column. Where responses can be further sub-divided, these sub-divisions have been listed underneath the relevant theme. Where one response covers more than one theme, it may have been included in more than one section. Where multiple registrants raised the same issues (or very similar issues), some responses have been omitted.

	• How do we do face to face assessments and ensure we have offered every possible chance of fair assessment? • Completing safe and robust Best Interests assessments DoLS • Not being able to visit P • Questions about how MCA / DOLS can safely be enacted. • Completing MCA's, no PPE • Ensuring capacity assessments are undertaken that are valid and do not always mean a face to face visit • Assessing capacity without direct contact with P. Assessing DOLS without seeing P in their care setting. • Obtaining instructions from my clients, organising court hearings • Being able to meet the statutory requirements of the MCA 2005 in undertaking assessments for the purpose of DoLS • Ability to visit RP's on hospital wards without increasing risk to infection • Delivering advocacy services at this time • Access to clients, overly restrictive practices • Assessment of capacity in planning for treatment given push to reduce patient visiting hospital
<u>Safety and wellbeing of staff</u> • Lack of PPE • Staff anxiety • Staff shortages • Difficulties of working from home • Managing childcare • Changing needs of workforce • Keeping staff safe	• Time to complete assessments of capacity assessments, patients refusing entry to professionals, care homes closed, staff anxiety • Staff shortages, increased demand. DoLS backlogs and impossibility of full legal compliance. Guidance for acceptable practice. • Completing MCAs, no PPE • Trying to work at home and home school a 6 year old and 14 year old at the same time • Response and support for the rapidly changing needs of the social care workforce • Lack of PPE to supply to carers. Carers not working due to being symptomatic, lack of testing • Ethical issues such as what to do in situations where patients need care and treatment but there is no adequate PPE for staff • Getting staff working from home safely, prioritising most vulnerable, assessing capacity creatively • Lack of staff • Keeping patients & staff safe • Safeguarding, hospital discharge, ensuring staff safety, maintaining safety of vulnerable individuals • Supporting student healthcare professionals • Access to PPE • Support for unpaid carers, availability of paid care staff, PPE for unpaid carers & social care staff
<u>General safety and wellbeing of vulnerable and isolated individuals and their families</u> • Implications of isolation for mental health (e.g. no visits from family members)	• COVID-19 fraud scams, supporting cash-dependent individuals • Safe discharge and DoLS/MCA planning, safety of isolated communities and who's supporting people, Scams and abuse of vulnerable • Access to money and specific capacity assessments • High risk clients who are now even more isolated so even higher risk • Provision of support • Ensuring good enough social care for people with learning disabilities and human rights which seem to be ignored

• Implications for wellbeing of carers (e.g. lack of respite care, families of vulnerable individuals who pose a risk to others) • Access to support and resources (e.g. funding, food, etc) • Helping vulnerable individuals to understand the pandemic and its implications • Anxiety caused by the pandemic • Ensuring that vulnerable individuals are safe from neglect and abuse • Protection and support for unpaid carers	• People who live in residential/nursing homes not being able to have any contact with their family. • Advising families who are concerned about preventing loved ones from going out- who may lack capacity • DoLS increases in restrictions for those that lack capacity, particularly with regards to accessing services & family contact • Inability to meet face to face • Charity services have stopped • Supporting people who are vulnerable and self-isolating • Hospital discharges of objecting patients; care home 'lockdowns'; DoLS assessments without having face-to-face contact with P • Acting as deputy for vulnerable clients living in their own home, particularly ensuring ongoing provision of care and nutrition • People in self isolation with disorders or disturbances of mind or brain who may be at risk / presenting risk to others • Ensuring that the vulnerable are protected against abuse • Adapting our software for the expanded workforce. Plus, I volunteer as a home carer, so infection control is priority • Transparency about process and criteria for family visiting people living with dementia for their emotional wellbeing and/or EOL • Practical support for families who support networks are no longer available as well as financial challenges faced as a charity • Delivering essential services for vulnerable adults, subject to Deprivation of Liberty Safeguards • Ability to visit RPs on hospital wards without increasing risk of infection • Advising family members, parents, attorneys & deputies how to support P during the pandemic • People with dementia living on their own- unable to understand 'self-isolating' instructions, and feeling isolated from family • That people do not come to unintended harm for a health reason other than COVID-19 because of the COVID-19 response • Maintaining safeguarding of vulnerable children and adults • Vulnerable brain injured clients, who lack capacity to make decisions, but do not fall into the government 'vulnerable' group • Clients' access to domiciliary carers • Ensuring families are safe • People living with dementia in isolation and how they and their carers can cope • The isolation of the vulnerable. Who are we missing? • Client anxiety • Carers having no access to respite - Individuals with dementia not understanding COVID-19 and social distancing • Lots of queries about keeping people with dementia safe • Impact on admissions/discharges re transforming care cohort and capacity to support people in crisis safely • Large numbers of concerns of people living with diabetes and access to food supplies • Ensuring people are safe from abuse and neglect at this time. • Communicating with people with learning disabilities • Mental health inpatient care and Isolation • Working with adults with learning disabilities who are struggling to understand the regulations associated with the "Lock-Down" • Not being able to support our carers on a face to face basis

	• people lacking capacity self-discharging from care into their family homes due to fear • People with LD not understanding the pandemic • People with learning disabilities understanding the guidelines and following them • Helping people with a learning disability to understand the lock down • Safeguarding, hospital discharge, ensuring staff safety, maintaining safety of vulnerable individuals • The worry around UASCS, often 16-18 years old, having travelled through Italy - accessing placements and care • Support for unpaid carers, availability of paid care staff, PPE for unpaid carers & social care staff • Care package sustainability • Supporting homeless people to self-isolate who are alcohol or drug dependent • Support for unpaid carers, availability of paid care staff, PPE for unpaid carers & social care staff • Practical support for families whose support networks are no longer available as well as financial challenges faced as a charity
<u>Information / guidance</u>	• Lack of guidance around DoLS in pandemic • Lack of leadership • Queries re undertaking MCAs • DoLS, MCA, health not knowing DoLS or MCA well whilst being charged with being the people most appropriate to do assessments • Getting staff at all levels to recognise the MCA & DoLS will still apply • Staff shortages, increased demand. DoLS backlogs and impossibility of full legal compliance. Guidance for acceptable practice. • Lack of clear guidance • Transparency about process and criteria for family visiting people living with dementia for their emotional wellbeing and/or EOL • Response and support for the rapidly changing needs of the social care workforce • Uncertainty re: work expectations. • Understanding changes happing to MCA and DoLS practice • Trying to give people the correct information on their rights, including rights in social care and health care • Being unable to see people face to face, no guidance under the coronavirus law for DoLS • Keeping information to students updated • Keeping already under pressure staff alert to the likely rise in some categories of safeguarding issues • Receiving information from care homes in regard to the paid RPR role and low numbers of IMCA SMT referrals • Lack of coherent guidance on the MCADOLS statutory duties • Rapidly changing guidance
<u>Advance planning</u>	• How do we explain the options for citizens re advanced planning so that they are clear of their options? • Supporting a larger amount of people to plan ahead

	- Supporting future planning, offering protection and safeguards, carrying out core functions. Being accessible.
Staffing and resources	- Meeting Article 5 obligations and DoLS staff redeployment - Supporting our clients to continue training in the social care sector - Supporting AMHP students on practice placements - Most health and social care staff moved to front line services and so little monitoring and assurance work possible. - Staff training - Assessing service users, not sufficient staff - PPE availability, quarantining staff, lack of COVID-19 testing - Supporting student healthcare professionals - Care package sustainability - Resource provision for adult social care providers - and knock on effects - Lack of staff - Supporting our clients to continue training in the social care sector - Supporting AMHP students on practice placements - Losing DoLS team staff to assist hospital discharge
Legal and human rights issues	- Human rights considerations, how to keep people safe in situations where they may lack capacity around decisions about COVID-19 - Ensuring good enough social care for people with learning disabilities and human rights which seem to be ignored - Care home access, suspension of DoLS, people unable to undertake capacity assessments face to face - DoLS assessments / Protecting patients' rights vs protecting their lives - Protecting and human rights - Advising families who are concerned about preventing loved ones from going out - who may lack capacity - Why are human rights missing? Have people forgotten MCA amidst the crisis? - Getting staff at all levels to recognise the MCA & DoLS will still apply - Staff shortages, increased demand. DoLS backlogs and impossibility of full legal compliance. Guidance for acceptable practice. - DoLS - increases in restrictions for those that lack capacity, particularly with regards to accessing services & family contact - The erosion of civil liberties on the pretext of the public good - The lock down of congregated services without proper legal safeguards around the individuals, or opportunity for them to leave. - The legal support for vulnerable people - Maintaining legal framework - Depriving people of their liberty for the protection of others - Are restrictions always proportionate - Guidance regarding the prioritisation of DoLS requests - art 6 ECtHR appears to be taking a bit of a back seat at the moment - Obtaining instructions from my clients, organising court hearings

	• Conducting DoLS assessments, people who won't comply with social distancing • Promoting people's rights vs measures in place to protect public health • Upholding rights of vulnerable adults whilst their health is protected • Court of Protection backlog/delay • Equitable treatment for people with learning disabilities in hospital • Application of statutory requirement in days of staff shortages and social distancing • Upholding rights. MCA compliance. Delivery of statutory service. • Balancing human rights / freedom and safety • Protect life vs protect rights • Ethical issues such as what to do in situations where patients need care and treatment but there is no adequate PPE for staff • Getting staff working from home safely, prioritising most vulnerable, assessing capacity creatively • To be able to adapt to new ways of working but the same time, adhering to legislative requirements and best practice • Keeping up with new legislation and supporting staff who are receiving multiple updates on a daily basis • Human rights and restrictions • How we support rights, consent when supporting hospital discharges from NHS acute and mental health hospitals • Access to statutory advocacy • Meeting Article 5 obligations and DoLS staff redeployment • Ensuring that Ps voice is still heard when hospitals are currently rapidly discharging people • Vulnerable brain injured clients, who lack capacity to make decisions, but do not fall into the government 'vulnerable' group • Access to clients, overly restrictive practices • Unable to visit, restrictions on family contact (article 8 restrictions) • Protecting rights • Mental capacity practice- best interest decision making and ethical forum withdrawal of care. DoLS framework in respect COVID-19 • Maintaining an ability to promote and maximise afforded by the MCA and the protection to individuals Article 5 rights • How decisions are being made about how may have access to acute care as the pandemic progresses • Wanting to provide proportionate guidance re: DoLS in acute hospital setting in context of current climate • Concern about maintaining human rights when systems and people are under extraordinary pressure • Juggling the competing priorities and legalities of interventions • Deprivation of liberty safeguards and restrictive practices • How to use the MCA and best interest under the COVID-19 Bill • People lacking capacity are being herded from place to place for their rights as people
<u>Other</u>	• Transferring patients out of hospital • DoLS practice • Non means tested funding in DoLS cases, lack of resource by LAs/NHS to deal with COP

	• How to keep non-compliant capacitated patients in self isolating side rooms on the wards • Teaching and research continuation, ensuring students graduate • Mental capacity in Shared Lives arrangements during the Coivid-19 pandemic • Adapting our software for the expanded workforce PLUS I work volunteer as a home carer, so infection control is priority • Isolating those with significant cognitive impairment • Potential lack of raising safeguarding concerns by clinical staff, suspension of face to face training • Independent sector care homes and private hospitals • Helping people understand the impact of self-isolating, social distancing and shielding

Webinar 2 – April 28th, 2020

COVID-19, DoLS, and Best Interests

Registrants were prompted with the following questions:

1.What difficulties have you encountered in the context of the pandemic in making decisions for persons lacking capacity?

2. What other difficulties are you encountering in applying the MCA in the context of the pandemic?

There was significant overlap in the responses to these two questions, and they have therefore been combined.

Responses from registrants: [17]

Theme	**Issues Identified by Registrants**
Access and assessments a) General worries about lack of face-to-face communication • There were over 100 examples of the kinds of statements listed opposite.	• Face to face assessments • Access to that person • Patient access • Face to face assessments/reaching service users who have to self-isolate • Difficulties in getting access to patients in community to carry out assessments • Not being able to complete face to face assessments of capacity
b) Lack of facilities / technology / training for remote assessment • Care homes do not always have access to the relevant technology, e.g., Skype / Zoom /	• Use of technology • Interviewing using technology • Setting up virtual assessments with care homes and hospitals refusing any visits and not being able to support virtual assessments • Difficult without face to face and staff are very busy and not always able to use face time/skype or lack these facilities • Not being allowed to visit. Remote assessments not being facilitated or successful.

---

[17] This table contains the responses of the first 350 registrants. Registrant responses are given in the right-hand column, and have been sorted according to theme, which is given in the left-hand column. Where responses can be further sub-divided, these sub-divisions have been listed underneath the relevant theme. Where one response covers more than one theme, it may have been included in more than one section. Where multiple registrants raised the same issues (or very similar issues), some responses have been omitted.

Facetime and phone lines • There are not always sufficient staff available at care homes to help with remote assessments	• Accessing people due to restrictions. Lack of technology for staff to use video conferencing to assess. • Remote assessment is difficult. Concern that the voice of the individual may not be heard in the context of decision making. • Undertaking virtual assessments • Remote assessments - care homes lack facilities e.g. Skype • Supporting people when we cannot see them face-to-face, with limited access to video calling also • Inability to directly try to communicate with person as some homes don’t have Skype/Zoom or FaceTime facilities • Ability to complete virtual assessment has been very challenging • When it is hard to hear P over the phone, some care homes do not have Skype/WhatsApp/Zoom etc abilities • The support available from care staff and availability of phone lines to support with 'virtual' MCAs • Inability to access to assess on hospital wards, lack of options as alternative support • Care homes struggling with video calling and homes not having any access • Regional variability. Care homes too stressed to facilitate assessments remotely or to share full care plans. • Lack of appropriate training for staff to adapt to telephone/video assessments
c) Concerns about limitations of remote assessment / whether remote assessment is appropriate in all cases In particular: • Where individual is not able to use relevant technology • Where individual is non-verbal • In cases of fluctuating capacity • Remote assessment means that advocates / relatives are sometimes not present • Harder to assess coercion and control • Harder to assess risks when not able to see the environment	• Limited means to ascertain views and wishes, especially where assistive technology is not appropriate • Not being able to undertake assessments as individuals not able to engage using technology and face to face contact not possible • Not being able to visit, telephone and video calls not appropriate for a lot of the people we support. • When P finds it hard to speak over the telephone • Undertaking capacity assessments by video/phone when the person does not communicate verbally • Effectively involving P remotely • Looking at remote MCA, concerns that individuals who are not verbal or do not engage well with people, will be disadvantaged. • Difficult without face to face and staff are very busy and not always able to use face time/skype or lack these facilities. • Advocates/relatives not being able to accompany the patients and give opinions • Finding it inappropriate due to person's presentation to try and contact them using technology. • Assessing mental capacity and establishing a person's views at arm's length when their communication skills are limited • Not being with a person in their environment hampers creative engagement and communication and opportunity for observation. • Ability to complete virtual assessment has been very challenging • Coercion and control harder to assess. Soft skills harder to use. Support staff to help service users access equipment. Ethics. • How to carry out assessments of capacity remotely when the person doesn't wish to engage • Communication, Skype and telephone are not great ways to communicate with someone with limited communication • Not being able to see my clients where social media is not appropriate

	- Ensuring that the adult's voice is heard when having to rely on others to provide the information - Being unable to assess client's non-verbal cue & having to rely solely on the report of the S.12 Dr - No face to face capacity, fluctuating capacity is difficult to manage - We are not decision makers, but it is difficult ascertaining P's wishes and feelings remotely
d) Other concerns relating to remote assessment - GDPR - Security concerns about relevant technology	- Assessing remotely /GDPR and social media platforms - Assessing capacity remotely and GDPR issues related to creative technology - Access to clients in closed care homes. Security concerns re virtual platforms.
e) Difficulties in accessing / communicating with colleagues / professionals in other teams	- Access to multi-disciplinary team members - We deliver training, so the difficulties are in doing that face-to-face - Getting and keeping in touch with professionals - Communication with understandably busy staff - Working with other professionals and organisation to help support the MCA - Supporting ward staff at a distance to use MCA well - Difficulties getting the team together - Being able to arrange a multi-agency approach when considering complex decisions - Communication as all working from home
f) Access to relevant documentation - Care home staff too busy to send these across - E.g. care plans, capacity assessments, risk assessments medication records, support plans, daily records - 'Not being able to fully access medical notes that may temporarily impact their capacity, e.g. with chest infection, delirium etc.'	- Not being able to meet with the person face to face to complete capacity assessments. Not having access to care plans. - Relying on care homes to send across paperwork for desk top assessments (they are very busy) - Accessing care plans, capacity assessments and risk assessment. - Getting care/support plans, medication records and daily records from care homes - Care Homes busy and cannot provide electronic care information - Not being able to fully access medical notes that may temporarily impact their capacity e.g. with chest infection, delirium etc - Sending documents out to people not being in office - Regional variability. Care homes too stressed to facilitate assessments remotely or to share full care plans - Acquiring information pertinent to the assessment

Concerns that processes intended to protect rights are not being upheld • Concerns that there is a general sense that MCA does not apply during the pandemic, or that MCA / DoLS ‘falling to the bottom of priority pile’ • MCA considerations overlooked as a consequence of time pressures (e.g., in hospital transfer / discharge) • Advocates not being involved • Concerns about discrimination • Fewer referrals being made	• Preventing flexibility to the point where vulnerable people's human rights are not adequately protected • People being transferred out of hospital without consideration of MCA process • Getting Care Homes to understand MCA DoLS • Persuading senior management that DoLS work needs to continue • Not directly yet but clear assessments are not being done where they are required • Decision being made for people without consultation or MCAs being completed • Virtual DoLS assessments, moves without BI decision due to provider staffing capacity • Staff deciding without recourse to me as parent or to Registered Manager without a scheme of delegation • Compliance with the national guidance in care home sector, people who present with behaviour which challenge services • Reduced consideration for the need to [assess] capacity as often choices about discharge destination are limited due to the pandemic • That the MCA is not being followed and advocates not involved • The Mental Capacity Act is not being referred to in guidance and professionals are not involving IMCAs when they should • Ensuring LD patients/MCA patients are not discriminated against • Ensuring Human Rights and MCA legislation is not overlooked by frontline staff. • Being asked to complete reviews without access to the patient to obtain consent or make a best interests MCA decision • There appears to be a decline in DoLS authorisations being requested • No assessments for DoLS in acute setting so urgent lapses • Lack of time. Staff can now claim this is unimportant. • Clinical time to complete best interests decisions in relation to push for quick discharge • Advising other professionals and organisations to keep trying to be creative in undertaking the MCA • Various teams in health and social care seem to think the MCA no longer applies • None at the moment although I suspect that adherence to the MCA has diminished in the light due to rapid decision making. • People thinking the legislation does not currently have to be followed • That new discharge processes are not correctly supporting staff to follow the MCA • Low referrals to advocacy – it’s like everyone has forgotten to refer • Easements in Care Act and speed of discharge works against continuing sufficient MCA practice. • There is a bit of an assumption that all that MCA doesn't matter now • Decision Makers appear to be referring less at present • Decision makers appear to be referring to IMCA and RPR less • There may also not be an appropriate person to assess capacity. • Reminding colleagues, not to just take over in panic mode, but allowing choice where possible • There are instances when it’s just not being applied, and P’s voice is being lost completely. • Lack of clarity in some areas about whether the MCA still applies. • Lack of observance of the MCA by health professionals

	• Competing with other priorities i.e. making sure people can get food and medicines at home • Not being able to fully follow the capacity/BI process for DoLS outlined in MCA/ DoLS code. • Individual workers' beliefs that MCA does not apply • Unable to maximise the person's capacity • MCA and DoLS falling to bottom of priority pile • Legislative changes seem to be moving away from HRA and P having a voice.
<u>Hospital discharge and transfers</u> • Pressures to discharge as soon as possible (i.e. as soon as person is deemed physically fit enough) • As above – speed of discharge hinders processes related to MCA • Problems with care homes not accepting people who may have COVID-19 because of infection concerns • How to plan discharge in the case of people who lack capacity and test positive for COVID-19	• People being transferred out of hospital without consideration of MCA process • Care homes will not accept back without testing for Covid which we do not due routinely for patients who do not have symptoms, • No real difficulties to date - speed of some discharges and MCA decision making could be a problem • Transferring patients quickly from hospital to care homes • Discharge planning and DoLS re persons lacking capacity who are COVID-19 positive • Hospital discharge • Managing escalating behaviours and safe hospital discharges • Speed of discharges and lack of consultation • Clinical time to complete best interest decisions in relation to push for quick discharge • Urgent placement changes, hospital admissions/discharges particularly where the person is Un befriended • Imperative to discharge from hospital as soon as clinically fit • Pace of discharge from acute setting • That new discharge processes are not correctly supporting staff to follow the MCA • Easements in Care Act and speed of discharge works against continuing sufficient MCA practice. • Rapid discharge to community • Care Homes (as a group) refusing to take patients being discharged from hospital who may be C19+ stating its guidance not law • Hospital discharges • Movement of service users from hospitals or from care homes to designated care homes under COVID-19 arrangements
<u>Tensions between wider public health concerns and rights of individuals</u> • How / whether to consider interests of others when making decisions about best interest: 'MCA is only about harm to person' • 'Restrictive practices within care homes'	• How best interest of an individual also includes taking into account best interest of others • COVID-19+ confused patient and risk to others (MCA is only about harm to person) • Nonadherence to self-isolation in an acute clinical setting- resulting in anxiety and potential overt restrictive practice • What people we support can and can't do vs our duty of care support. Staff are worried. • Have written guidance supporting longarm assess, with an emphasis on protecting human rights but recognising COVID-19 impact • Restrictive practices within care homes • Someone with dementia who is mobile and active and showing symptoms of COVID-19, Care Home asking how to manage? • Conflict between public health versus best interests

• Worries about practices of medicating / isolating individuals who are not complying with lockdown • 'BI decisions where the RP is objecting to isolation – is it public health or DOLS?'	• Isolating a young person in a group living environment if they are not following lockdown guidelines • Pressure from homes/other prof to medicate 'wandering' incapacitated individuals to prevent spread • Person in supported living going out, no social distancing. Risk to her and others. • How best interest of an individual also includes taking into account best interests of others • That effect of restrictions being applied due to public health concerns • BI decisions where the RP is objecting to isolation - is it public health or DoLS? • Availability and guidance on PPE. Who is the risk to for younger people? MCA is about risk to P.
Advance care planning Concerns around DNACPR, in particular: • 'Blanket DNACPRs' • 'GPs contacting re DNACPR' • How to help people consider DNACPR • 'Lack of family / advocate consultation … around DNACPR'	• Discussions around advance care planning • Timely best interest decisions and confusion around advanced care planning and DNACPRs • Blanket judgements around DNACPR • GPs contacting re DNACPR • Lack of family/advocate consultation especially around DNACPR • Advance planning • DNACPR conversations and capacity/BI • Patients who may not have considered DNACPR or advance decisions and how this is now carried out • Serious problems connected to DNACPRs and end of life planning • Issues with GP re DNACPR • Blanket DNACPRs
Difficulties around compliance with lockdown • How to proceed in the case of non-compliance with lockdown • How to proceed when there are doubts about compliance with lockdown • How to help individuals to understand lockdown • Family members not complying with lockdown	• Lacking understanding of reasons for restrictions and subsequent "compliance" • Doubt about capacity to adhere to self-isolation • People not maintaining social distancing requirements • issues relating to supporting people in isolation and how this can be done safely when they lack the capacity to understand why • Non-adherence to self-isolation in an acute clinical setting- resulting in anxiety and potential overt restrictive practice • Compliance with the national guidance in care home sector, people who present with behaviour which challenge services • Supporting community and care provider colleagues with people who can't/won't self-isolate • What people we support can and can't do vs our duty of care support. Staff are worried • Carer's loved ones in hospital, lacking capacity and wanting to leave • Difficulty fully engaging P in discussions about options available and context of pandemic • Patients are still going out and unsure if they have capacity to make the unwise decisions

- Concerns about capacity to make decisions around self-isolation etc. - 'What is the relevant information to make a decision to act against social-distancing advice?' - Families keeping individuals locked in at home due to non-compliance with lockdown	- Client related decision to relocate to London against advice of professionals involved - Isolation for those who lack the capacity to make this decision - Someone with dementia who is mobile and active and showing symptoms of COVID-19, Care Home asking how to manage? - Infection control measure and compliance generally for my LD service users - When someone with dementia wants to leave their home as they don't understand what is happening - Keeping people safe regarding not going out and not understanding why - Helping people to understand the restrictions to going outside. - Isolating a young person in a group living environment if they are not following lockdown guidelines - Person in supported living going out, no social distancing. Risk to her and others. - What is the relevant information to make a decision to act against social distancing advice? - P not understanding current situation and not being able to cope with new restrictions - Restrictions due to the pandemic not being understood by people due to lacking capacity to understand etc the risks - Adherence to social -isolation and restrictions and how these are managed. - Family members not following guidance / risk assessments - People lacking capacity around social distancing/self-isolation. Providers struggling to know how to proceed. - People not understanding the need for lockdown and wanting to go out. Family locking people in
<u>Practical issues around wellbeing during lockdown</u> - Distress caused to individuals by the appearance of PPE - Impacts of a lack of visitors - Impact on carers, e.g. lack of respite care - Worries about scams - Concerns about distress caused to individuals who are in hospital without any familiar faces	- Access to timely support and communication with family - Contact issues with family/right to family life - Balancing support for volunteer assistance for those self-isolating with protecting the account holder - Difficulties being able to support the client in a timely way as government advice changes - Time constraints and the impact of no visitors - Isolating people in their own rooms - Increased restrictions and isolation - Role flexibility/ decreased options available, decrease in support/ respite services - Day care and carer not having time to self - Protecting individuals from scams - Not allowing visitors to visit family - The effect of restrictions being applied due to public health concerns - The difficulty and fear from the patient when assessing using PPE equipment. - Explaining treatment, supporting SUs who go to hospital without staff: familiar faces who support them to feel safe and secure. - Building relationships with people who are patients in hospitals - Taking people to hospital and not being able to support inside - though this has just changed - What is in a person's best interests in terms of providing long term care where the carers could cause infection

- Relatives wishing to take residents home from care homes - What is in a person's best interests in terms of providing long term care where the carers could cause infection. - ‘When contacting families, they are affected by the situation and the last thing they want to talk about is DoLS!’	
Lack of guidance	- DoLS lead. Major difficulties around no face to face contact. Lack of government guidance - Lack of OFFICIAL guidance from DHSC - Initially, it was waiting for DOH guidance re expectations around DoLS process in non-contact situations - Broad guidance regarding restrictions - Lack of guidance from LA - Truly applying he guiding principles, even with the advice provided nationally. Currently waiting for DHSC guidance. - No clear direction from DHSC re: MCA/DoLS - Legal requirements under restrictions, what can we do and not do? - Dealing with all the different guidance, no actual changes that are already in law (Mental Capacity Amendment Act 2019) - Changing guidance that appears woolly - Uncertainty around whether LPS delayed
Time pressures - Worries about the speed at which decisions have to be taken / the consequences of taking decisions at speed - Which decisions can wait? - Worries about the increased time taken to carry out assessments due, e.g. to lack of access to relevant paperwork.	- Time against patient and clinician safety - The speed at which decisions need to be made and the limited options this results in - Takes longer time due to care homes not able to respond in sending care plans or sparing staff - Time constraints and the impact of no visitors - Timely best interest decisions and confusion around advanced care planning and DNACPRs - I am very clear speed in which this has to happen is sometimes difficult - Lack of time. Staff can now claim this is unimportant - Clinical time to complete best interest decisions in relation to push for quick discharge - Imperative to discharge from hospital as soon as clinically fit - Pace of discharge from acute setting - Time to properly consider MCA and DoLS - Can it wait? How do we measure what’s considered urgent in other decisions that don’t follow a clear timeframe?

<u>Other</u> • Barrier to natural communication created by PPE • 'It's difficult to find information on P's relative risk from COVID-19 in any detail (if not over 70 or in the shielding category)' • Questions about the transition to LPS • Worries about the rise of domestic violence • Covering all 5 principles. In particular, 'Principle 2 - complying with offering support if this is a virtual assessment' and 'Homeless wanting to return to streets rather than accommodation - principle 3' and principle 5: availability / appropriateness of 'less restrictive options' • Staff shortages / redeployment of staff • Which decisions can be delayed?	• Hearing of incidents involving people who are the main carers for incapacitous partners, and what to do with partners then • It's difficult to find information on P's relative risk from COVID-19 in any detail (if not over 70 or in the shielding category) • Role of CCDC and application of the law • Practicable steps • GPs not being aware of resources and the reasonable adjustments • Lack of time. Lack of staff understanding. Lack of candour and silly 'shortcuts' such as accepting bamboozled assent • Carrying out assessments and ensuring the 5 points are covered • People seem to have forgotten what they already know. • Workforce and identification • Relying on second-hand information more than before • Issues related to domestic violence, self-isolation and undertaking MCA assessments • Lack of clarity on when, how or if transition to LPS may take place and if not, how DoLS are sustained • Cases where there are objections • No real difficulties to date - speed of some discharges and MCA decision making could be a problem • Giving correct advice to community staff • COP not prioritising property/affairs applications • Cases that are objecting, less restrictive alternatives not an option • Speed of discharge requirements • Limited support services /ward access to see patient • IMCA SMT decisions • Not being able to obtain client's wishes or objections directly for them. • Not being able to implement non-instructed advocacy • Unable to isolate them if needed • Involving people to ensure person centred decisions • How physical health can affect a person's capacity • The nature of the decisions has changed, and we are being asked to advise on situations that we have never come across before. • If DoLS is need when dementia and put into isolation in their rooms • MCA assessments in the acute hospital trusts • Agreeing who can complete assessment and which local authority if placed out of county is responsible for assessment • Difficulty due to unavailability of court intermediaries • Redeployment of staff into new areas of care and new cohort of patients • How to teach the pre and post qualifying SW, nursing and OT workforce to respond • Staff shortages • Principle 2 - complying with offering support if this is a virtual assessment • Capacity judgements by GPs and documentation • Section 12 doctors not yet accepting assessments • Homeless wanting to return to streets rather than accommodation - principle 3 • Hospital trusts not communicating with LAs and representatives • Capacity and home care

	- The key element of whether you can delay a particular decision - Application of DoLS due to remote access to people, gaining assurance restrictions are proportionate and appropriate - Taking practical steps to enable the person to understand the information - What practical\ creative steps can be taken to protect service users and professionals whilst still abiding by the MCA 2005 - Getting solicitors to take on CoP cases - Concern re speed of response re safeguarding concerns - Advising acute and community providers how they can assure us that systems are safe - Blanket use of ResPECT plans - Not being able to advise with confidence that someone else might be leading questions - Movement of staff who don’t know the incapacitated person as well - Legal requirements under restrictions, what can we do and not do? - Staffing and remote working - Threat of coercion - Least restrictive - Assessing capacity - Heightened anxieties of families and some professionals - Isolation for people lacking capacity - Application of MCA or DoLS for drug and alcohol users, hoarders and rough sleepers and therefore management of risks - The absence of non-verbal communication because of hidden facial expression behind masks is really hard - DoLS offices response as I understand many staff have been redeployed - When do DoLS apply as people lacking capacity are not allowed to leave their homes as they would previously - Ability to no longer make their own decisions - The difficulty and fear from the patient when assessing using PPE equipment - Reliance upon managing authorities to establish whether the citizen has capacity in relation to specific issues - Medication review for people living with dementia - Competing with other priorities ie making sure people can get food and medicines at home - DoLS team members understandably pulled into other areas of work - Lesser restrictive options e.g. family contact and non-compliance with social distancing - Social workers and other professionals self-isolating or prioritising other work

3. How have you resolved decision-making difficulties in the context of the pandemic?

<u>Theme</u>	<u>Issues Identified by Registrants</u>
	- Supporting staff in being creative and use of virtual assessments - Telephone and Skype, although still challenging

Use of technology to facilitate remote collaboration and assessment - Use of Skype, WhatsApp, Zoom, etc. to facilitate remote assessment - Questionnaires sent to care staff to be completed in advance of assessment / discussion	- Where people have access to technology or WhatsApp it makes it easier - Currently exploring the use of different communication platforms - Remote working, use of IT systems/video/conferencing calls - Spent a lot of time researching and now delivering virtual training - Lots of telephone contact/consultation - delaying non-urgent work - Using valid equivalents where possible for MCA & MH assessments for DoLS. Desktop assessments + phone call where P is able. - Mental capacity completed by proxy and remotely. The use of equivalent assessments - I send information and questions before hand and ask for a member of staff to go through with the person beforehand - Via national platforms, webinars, virtual meetings - Yes by using remote working, scheduling frequent catch ups - Using Skype close liaison with legal teams - Video conferencing, input from carers - Performing telephone consultation whenever possible - Some use of iPad and mobile phones with face time technology Also using staff on site with the person to ask questions. - Zoom, adobe sign - Same use of less restrictive and proportionate outcomes for the citizen completed virtually with all the usual contributors - Remote access and use of a refined 3B process - Remote decision-making methods - Best interests meeting /decision making via email - DOH have since issued guidance. Use of phone, email to relatives/providers/RPRs/ RPs (where possible) - Used proforma questions for care homes to complete and return before making call to discuss further - Telephone calls linking services and family so virtual meeting
Use of previous equivalent assessments	- Reliance on equivalent assessments, consulting with those who know the adult - Using equivalent assessments where possible for DoLS - Relied on recent relevant information, consulting with interested parties and relying on my professional experience - Only dealing with those I have assessed previously, however may not be priority cases - Using previous reports / assessments if there is no change - Greater reliance on more collateral evidence, slowing down processes to allow more analysis of evidence. - Remote assessments using emailed notes, electronic records and previous assessments, but this is not always forthcoming - Used information from staff, previous assessments from last authorisation and contact info from other reports if available. - Use of previous capacity assessments and short DoLS authorisations
Collaboration	- Multi agency working - Discussion with colleagues in clinical ethics meeting - Trust has a clinical advisory group to review concerns and guidance for staff - Link in with GM and national DoLS network - Via national platforms, webinars, virtual meetings

	- Using Skype close liaison with legal teams - Lots of consultation with senior managers and legal - Close liaison with social services, police, care agencies, families etc Much greater MDT working than I've needed before. - Raising issues with relevant practitioners and commissioners and safeguarding where necessary - Constant meetings re clinical governance - Support to staff to discuss complex cases - Liaison with providers though contracts and monitoring - Safeguarding team to be involved in decision making / policy review around ethical issues such as DNACPR - Discussions with the company HR, legal and duty quality teams - Using coms to remind medical professionals of the need to consult and working with the local advocacy provider
Reminding others of duties associated with MCA	- Reminding people of need to continue best practice and look at alternative ways of trying to do that - Informing GPs and managing authorities of the duties under the MCA 2005 - Updating GPs regarding requirements of MCA - Reminding people of the MCA principles - Ensuring that the MDT are aware of the need to consider patient's capacity - Reliant on front line staff to ensure implementing MCA and robust care plans in place - Any issues for decision making are in line with MCA - Supporting the team to consider and record MCA and best interest - Using comms to remind medical professionals of the need to consult and working with the local advocacy provider - Not directly yet but clear assessments are not being done where they are required - Direct contact with provider on knowledge of incident to ascertain action to mitigate recurrence - Supporting the team to consider and record MCA and best interests
Family and / or carers assisting with assessment	- Reliance on equivalent assessments, consulting with those who know the adult - Collateral contacts and other professionals and/or carers (informal & formal) - Liaising with care staff to assist - Requesting a member of staff to be there when I speak to P to 'translate' for me - I have asked carers to fill in the relevant sections they can and email to me so I can then add how I am unable to visit - Doing the best that we can to carry out work over the phone and have in depth discussions with various members of staff - Use of telephone and opinion of family and carers - We are looking to combine support for service user to contact family with the assessment of capacity

	• More detailed consultation with others to establish P's views. OK as long as no dispute!
Have as yet been unable to resolve problems There were around 20 responses that indicated that problems had not been resolved. A selection has been included opposite.	• Awaiting government guidance • Not really • No • We haven't. We've failed at proper implementation and values are not embedded • Haven't for people who are non-verbal • Ongoing • Not yet resolved • I don't think we have. We are making those decisions as we would patients admitted with a delirium. • No but continue to challenge
Delaying decisions	• Remote working gathering clients' views over the telephone / other options where possible. Otherwise decisions must be delayed. • Monitoring and prioritising. Assessments not progressed at present. • Lots of telephone contact/consultation - delaying non-urgent work • I have postponed some decisions. • Waiting for national guidance. Transparency. Freezing assessments if insufficient evidence available. • Greater reliance on more collateral evidence. Slowing down processes to allow more analysis of evidence. • Have had to adjourn hearings
Taking decisions with a view to reviewing them later	• Best interests decisions have been taken, rather than wait, we can circle back to reviewing the decision as soon as practicable.
Production of resources and guidance	• Trust has a clinical advisory group to review concerns and guidance for staff • Followed guidance and written clear practice guidance for staff to find creative ways to continue service • Use of MCA and least restrictive measures. We have developed our own guidance. • Provided our BIAs with guidance • Development of protocols and risk assessments • Supporting staff with up to date guidance from Government • Read and listened to advice and tried to give clear guidance to our managers and families • Agreed a regional response and understanding of how assessments will be completed • Our Legal Department and Safeguarding Team have agreed a process for a consistent approach. • Creating Resource Packs to share widely to support the accessible information standard • Easy read support, also activities in house as current lock down limitations trigger challenging behaviours • By creating online courses and video link trainings

Use of placements in cases of non-compliance with social distancing	• Offered self-contained hotel accommodation over Easter. Capacity re care to be reassessed urgently this week. • Emergency placement accepted in patient and carers best interest patient is settled into the home well
Least restrictive measures	• The decision is seen in light of the pandemic and recorded so it means sometimes the least restrictive option is not available • Use of MCA and least restrictive measures. We have developed our own guidance.
Risk assessment	• Development of protocols and risk assessments • Working together with local authority colleagues to make a pragmatic decision based on risk assessment • Completed risk assessment
Other	• Common sense! • People are mostly deferring to public health advice and reluctant to make any exceptions • Factoring in the wishes of the person that they would not want to harm others • Weigh MCA vs COVID-19 legislation • Followed information I have and tried to agree protocol that other leads are using in region • Yes - in an advisory capacity to GPs especially for patients with learning disabilities • Hosting provider Zoom so that providers don't feel out on a limb • Desktop assessments • Sought COP intervention • Comms • Staff deciding without recourse to me as parent or to Registered Manager without a scheme of delegation • Keeping abreast of national guidance so I can advise and support colleagues accordingly • A proportionate response to the best interests checklist • Recent referral to the courts for direction re urgent DoLS authorisation • Falling back on "reasonable and proportionate" elements • Business as usual - just a lot quicker at times • Working together with local authority colleagues to make a pragmatic decision based on risk assessment • Dose of pragmatism, realism and flexibility • Awaiting management agreement- have drafted reports and emails • RAG priorities • Through agreed governance routes within Council • Ethical framework • Case by case decision • Advising on using PPE as standard, making the most of getting residents out into the garden too • Gathering information and views from a wide range of sources • Alternative arrangements have been put in place and circulated to all staff. • Remote access and use of a refined 3B process • Creativity and ethics

	• Involvement, accessibility, being person centred, being clear • Discussed support services that may be able to support MCA, but recognised that this may not be possible - considering ethics • Explaining with easy read or video information of the need and the change • Trying to utilise MCA as usual • Imagination

Webinar 3 – May 29th, 2020

Public Health and Human Rights in the COVID-19 Pandemic

Registrants were prompted with the following question:

Has the pandemic given rise to care dilemmas in which you have faced a choice between the protection of public health and respect for human rights? If so, please share an example.

Responses from registrants:[18]

Theme	**Issues Identified by Registrants**
Individuals who lack capacity wanting to leave their homes ***I*** Residents of (e.g.) care homes isolated I their rooms	• Isolation of older people in their own rooms to prevent the spread of the virus in care home settings • Restricting movements of P who has COVID-19 • How to provide specialist care to COVID-19 positive, neurologically impaired patients who want to ‘wander’ on a ward with no other COVID-19 patients • Advice to shielding people paternalistic view that people should never go out • People with dementia not understanding social distancing but wanting to be out for walks etc. • Residents who are very vulnerable have spent a lot more time in their own rooms during lockdown. • Yes. Individuals who have behaviours that are challenging to services to isolate, i.e., wandering and hitting out • Lockdown of supported living • A service user wishing to roam in hospital, care homes limiting visits from family

---

[18] This table contains the responses of the first 350 registrants. Registrant responses are given in the right-hand column, and have been sorted according to theme, which is given in the left-hand column. Where responses can be further sub-divided, these sub-divisions have been listed underneath the relevant theme. Where one response covers more than one theme, it may have been included in more than one section. Where multiple registrants raised the same issues (or very similar issues), some responses have been omitted.

	• Restriction of people who lack capacity in homes and hospitals in order to protect others • Where both hospitals and care homes have implemented blanket discharge and social isolation policies • A lack of clarity on the use of public health law and people lacking capacity in communal living / treatment arrangements • How to manage care home residents who will be deprived of their liberty • Neuro rehab patients wishing to leave and risk to others of COVID-19 on their return • COVID-19 and capacity issues around service users visiting public places such as shops • Restriction for everyone not just people who lack capacity to comply • Yes - blanket leave restrictions for people detained under MHA • Isolation of people who lack capacity in care homes • Using MCA to restrain / isolate a person who is COVID-19 positive. This shouldn't be done • Conflict between wishes of client who wants to travel to London to spend time with partner and new baby whilst living apart • Yes. Case of an older adult with cognitive impairment and COVID-19 positive insisting to go out to the local shops daily. • COVID-19 Hosp Pts lacking capacity and wandering are putting others at risk so can't use DoLS • Residents with dementia not being able to comply with social distancing • Some care homes are isolating residents in their rooms without MCA processes duly followed Clients with mental capacity deciding not to self-isolate and how we protect them and others • Yes, where individuals may not understand social distancing and are putting others at risk • People wanting to leave a care home but not being allowed • People wanting testing but not able to access them • Individuals with limited capacity wanting to attend outside places as usual • Tenants living in shared house. Tenant with dementia going out every day and not socially distancing from other tenants
<u>Restrictions on visits from family</u>	• Yes. Working in an LD setting. Contact issues between parents of adult children in care homes wishing to have contact • Yes. DoLS, restrictions on family visits, wellbeing of P • Restrictions on visits to older family members • Yes - care homes blanket banning families from visiting • A service user wishing to roam in hospital, care homes limiting visits from family • Yes, care home admissions, no visitors etc • Right to family life vs restrictions on family contact in hospital • Restrictive practice - such as visiting in hospitals (Mental health and learning disability). Lack of detailed robust guidance
<u>Overly restrictive practices</u>	• Restrictive practices introduced for people living in care homes which impact upon liberty including ability to access services • A care home has denied clients access to the telephone on grounds of hygiene.

	- The issue of the public health law being used to potentially over restrict people particularly in care homes - Using MCA to restrain / isolate a person who is COVID-19 positive. This shouldn't be done - When care homes have used increased restrictions for self-isolation to protect others - stair gates
Covid 19 testing in the case of individuals who lack capacity	- E.g. decisions over COVID-19 testing if no benefit to individual but will involve some restraint and risk from trying to do the test - Current testing is a big issue, including the involvement of advocacy and DoLS - Testing for people who do not have capacity to consent - Push for swab testing in care homes potentially testing those that cannot consent - Discharge when patient refusing swab/testing - testing, where someone lacks capacity and may resist testing, issues on who is test for? and isolation if not tested? - Taking swabs to confirm infection in patients who lack capacity - Impact of mass testing/two weekly testing - frequency and invasiveness - compliance with and without capacity - Yes - swabs for patients with dementia / reduced or fluctuating capacity - Patient refusal to swabbing without capacity - Swabbing of incapacitous people - Yes, preferred place of death
Hospital discharges and transfers and admissions to care homes - Pressure to discharge before ready in order to free up space in hospitals - Concerns about care home admissions in cases where individual may have COVID 19 and may therefore put other residents at risk - Individuals not allowed to leave hospital / move out of care home etc due to concerns about social distancing	- Care home refuses to admit to a vacancy for transfer as LA may seek to place from hospital. - Yes, in the way that hospital discharge would be better for some, but restrictions have made this difficult - Yes - Hospital discharge and preferred place of care/deprivation of liberty - Where both hospitals and care homes have implemented blanket discharge and social isolation policies - Pressure to discharge patients before ready to create space in hospitals - Hospital discharges - Yes, nursing home patients and transfers - Yes, care home admissions, no visitors etc - Should a person who is COVID positive be admitted to a care home potentially putting other vulnerable people at risk - A patient with LD and COVID-19 positive potential delayed discharge as unable to isolate at home - I had to make a decision between an individual's right to liberty and the risk to their own health, etc. if returning home
DNACPR and end of life care	- Yes, we are currently working with local homes supporting them to challenge GP's on blanket DNACPR decisions - End of Life Care / Deprivation of Liberty Safeguards / Best Interest Decisions for patients who are taken off ventilators in ICU - Yes, DNACPR without consultation

	• We, at the frontline, struggle with upholding people's basic rights to have a dignified death, when faced with restrictions.
<u>Assessments</u>	• Yes, having to assess remotely and to do the best we can • Whether it is OK to assess someone's situation without seeing them in person rather than by video link • Yes, this is the case for all DoLS assessments we need to carry out, but we are unable to visit the service users • Yes - when dealing with request for Deprivation of Liberty assessment before Government guidance was published • Impact on Care Act assessments • The whole debate about remote and video assessments • Yes. We have had to make decisions about when and how to conduct Mental Capacity Assessments. • Carrying out DoLS assessments • When to conduct a face to face interview in a care home • Video calls for capacity assessments - issues with internet connections and reduced ability to support person (P2 MCA) • In DoLS difficult to ensure full respect for Human Rights when we cannot physically assess people • Yes, we have been relying on telephone / Skype assessment as unable to conduct home visits to service users • Whether to assess someone who is shielding where face to face visit is necessary • DoLS assessments for those admitted to care homes from hospital due to lack available support in the community due to COVID-19 • Yes, how to do distance assessments while not unwittingly spreading the virus • Yes - as BIA in DoLs team I have a general concern that we are not visiting individuals in hospital to assess • Maintaining contact with clients in care who are shielding
<u>Other</u>	• Had 15 people who died of COVID-19 in one of the care homes • Looking at DoLS conditions- e.g., how to find alternatives to usual activities that are suspended during lockdown • Moving patients to nursing homes • Challenge of P's best interests vs employer duty to carer • Not directly, but clearly tensions in relation to deprivation of liberty • Yes - young lady who lacks capacity to have relationships but still CSE risk • Whether a client who is self-negligent in and struggling to manage at home should move to a care home • Yes - services not running • Death of a close relative and not being able to support in their hour of need • Care home task force where a lot of emphasis is on public protection although I stand my ground on respect for human rights • Required to write revised guidance for BIAs during the pandemic • Care homes are under pressure and take longer to send information (care plans, assessments) through

	• I had to intervene at the policy level re emergency legislation creating exceptions to mental capacity legislation • Restrictive practice - such as visiting in hospitals (mental health and learning disability). Lack of detailed robust guidance • Vulnerable client with support team. Sister (nurse) in risk work scenario but not following government guidance • As advocate I continue to support clients to access to their human rights such as Article 8 or Article 5 • Yes. We have article 8 breaches in care homes • Breaches of Article 8 due to care home lock downs • I have heard of dilemmas of care staff in other organisations struggling with access to PPE for staff and the clients' rights • Initial shortages of PPE resources and information in care homes violation of duty to protect life • We have had to limit contact with some clients due to other clients not respecting the government guidelines

Please share an example of how you (or someone you are aware of) has managed to strike a balance between protecting public health and respecting human rights during the pandemic.

Theme	Issues Identified by Registrants
Assessments	• Virtual capacity assessment visits • Using activity coordinators to support P with video conferencing • I have been able to co-work with learning disability specialist nurse who agreed to undertake capacity assessment on my behalf • BSL managed to assess via video link for DoLS • Remote DoLS assessments to ensure human rights are still upheld and the principles of the MCA are followed • We are attempting remote interviews • Remote monitoring, utilising visiting professionals to gain assurance • Remote DoLS assessments thereby protecting the health of care home residents while upholding their right to challenge their DoL • DoLS assessments • Video conferencing instead of visiting • We are having some success with remote assessments • Telephone assessments • Remote DoLS assessments, important to uphold article 5 rights but at the same time not to introduce infection into a home. • In many cases deciding that a video link is 'good enough' • Liaising and negotiating with Managing Authorities and Assessors to allow assessments take place when necessary • Re latter intro of concept of acceptance of capacitated decision based on understanding of risk and action to mitigate risks
Combating isolation	• Care homes that are streaming religious services to residents • Care homes streaming church services, carers using personal phone so clients can video call relatives • Enabling individuals to have as much freedom to walk around care homes by offering extra staffing and cleaning

	• Encouraging new routines • Using technology to facilitate contact • Arranging for client in supported living to have her own tablet to maintain contact with her mother • A personal example is that my mum has learned to use new technology to enable her to 'see' her family • Video conferencing instead of visiting • A Dorset care home turned a garden shed into a shop for their residents • Use of tech and creative methods of support including shop opening, online events • Care home staff finding new ways to assist communication between residents and their families whilst visiting has been stopped
Hospital and care home admissions, transfers and discharges	• Discharge to assess beds process • Effective discharge and admission avoidance • CCG funding private ambulance for conveyance under Mental Health Act, reduces delays to admission • Ensure that MCA guidance is followed on discharging patients
Honesty and information	• Openness and honesty • Being honest about the limitations / restrictions on our practice • Ensuring on balance we've done the right thing for P
Remote working and collaboration	• Video calls (Teams, Zoom & Skype) • We use telephones and video conferencing. Triangulation of information. Trusted assessors. Varying the timing. • Remote working within the Care Act easements • Guidance for care homes to ensure that consent and capacity is considered and individual's best interests not the home’s • By ensuring that guidance and successors are shared among networks • Close ongoing multi agency support work to better promote their understanding of the MCA and public health interface • Online work with client so they can continue to support the most vulnerable clients face to face • Discussion with another manager on these matters so she could gain some clarification prior to her team meeting
Compliance with lockdown	• Carers driving the person with dementia to a more isolated space • Keeping young adults diagnosed with ASD safe and away from other people when out taking daily exercise during lockdown • Threats to evict man with LD from residential home because he couldn't comply with lockdown. Human Rights Act applied • Restricting someone's movements without creating incidents for the person/their staff
DNACPR and end of life	• Care homes enabling end of life family visits • Discussion about personalisation and advanced decision-making • Holistic assessment; family views; robust MCAs and best interests decision, DNACPR and ReSPECT forms being completed correctly, with the instruction of an advocate • In another [place] a doctor has put in place DNACPRs and advance care plans to clients without consulting their EPA/LPA/RPR etc

	• Guidance for clinicians re: Best interests decisions in ICU at the Nightingale Hospital
Other	• We applaud the humanity of multi-agencies working jointly with acute health colleagues to support people with LD & Autism • A social worker - visited someone in care home, will progress best interests process in line with person's wishes • Using the discussion paper re managing testing and public interest • Ongoing involvement with patients in MH hospitals • Ensuring I am consulted on pathways • Safeguarding is represented in our ethics committee • Providing medical care by my husband to his patients • The agency was able to source PPE to protect the staff which then provided protection for the clients • It is more to do with public health colleagues knowing what is expected of them in situation when the relevant is harming others • Work with care home nurses, infection control team and GPs • Use of legal structures • Advice and frequent monitoring • Provision of artificial hydration and nutrition via gastrostomy and non-invasive ventilation in motor neurone disease patients • Discussion with clients regarding risks and balancing social care visits with mental health issues • Spoke with care home around blanket decisions. Informed them of the admission and care of residents during COVID-19 document. • Generally, as a regulator we are supporting all care providers and local authorities daily on such issues as this • Supporting health colleagues to develop capacity & best interest tools for COVID-19 testing • Balance between risk of admission into a care setting as public health risks had to be considered as part of best interests • Considering best interest and respecting person wishes /balancing with public funds • Proportionate restrictions in best interests • The company that cared for him found him a self-contained accommodation for the period of the COVID-19 • There is a fine line and it is difficult, but currently using government guidelines is helpful • Only by reminding providers of the Human Rights Act • I have helped facilitate PPE and fitting service • Referring to government guidance, discussing as team how to address concerns re urgent DoLS cases • Safeguarding referrals and safety plans requiring extra assessments and reviewing less restrictive options • Supporting the care sector without following the English model of amending regulations through legislation • Care homes redeployment and supporting commissioning colleagues

Are you aware of any situations in which we seem to be getting the balance wrong between protecting public health and respecting human rights? Please share an example if you are able.

Theme	**Issues Identified by Registrants**
Visits from / contact with family • In particular at end of life • In care homes and on mental health wards • Sense that adequate PPE would allow visits	• Care home visiting where the public health requirements seem to 'top trump' human rights. Family visitors are not just optional • Care homes on complete lockdown, no access for families to visit • Frustrated carer, husband in psychiatric hospital, has requested facetime with her husband, feels staff are not listening • Preventing family from staying with a relative while approaching end of life • I am concerned about blanket bans on visiting in care homes being commonplace • Not sure we have addressed the issue of P wanting to go home to die with family as last wish • Blanket restrictions on MH wards regarding visitors and not allowing leave • Not providing PPE for family and friends to be with the dying patient • If there were sufficient PPE and testing, patients would not be left to die without their families. It is a tragedy.
Individuals unable to go outside / confined to one room	• Able residents told they cannot go out at all even accompanied • Keeping patients in isolation a public health issue whereas it could be against patient's will • Many people with dementia have been kept inside regardless of their right to exercise • Due to shortages of staff in care homes, walks outside have not been happening • People in supported housing with tenancies being prevented from leaving • Blanket restrictions on MH wards regarding visitors and not allowing leave • Blanket policies to confine all care home residents to their rooms with no MCA / best interests and blanket DNACPRs • Long-term segregation and seclusion • "Blanket" policies in care homes to restrict residents to their rooms • Blanket decision making DNACPR. Residents in care settings restricted to their bedrooms for long periods • Blanket decisions being made to keep asymptomatic residents in isolation in their bedrooms for 14 days
Restrictions of transfer / leave from wards and/or care homes	• Yes. The CoP ruled my client should not be deprived of his liberty however his situation has remained the same due to pandemic • A client to have deemed to have capacity but unable to move back home due to pandemic • Short term care home placements being extended when an individual cannot understand they need to self-isolate • People in supported housing with tenancies being prevented from leaving • Blanket restrictions on MH wards regarding visitors and not allowing leave

Hospital discharges - Discharges rushed - People being discharged back to residential homes without having had a COVID-19 test - MCA not being followed during discharge / relevant assessments not being carried out	- Older people- being assumed to need extra protection yet also being discharged from hospital with lack of safety - MCA Assessments were not completed for discharge from hospital bed to pathway 2 or 3 for rehab etc - Hospital discharges where proper procedures not followed- rushed discharges leading to P feeling frustrated - Sending a person back to residential home from hospital without a COVID-19 test - Yes - Hospital discharges to care homes - Hospital discharge has caused me to feel most uncomfortable. Also, blanket approaches - Hospital discharges without following the Mental Capacity Act
DNACPR	- Misapplication of DNACPR: GPs writing to people to communicate advance decisions not to admit to hospital for treatment - Yes, Blanket DNACPRs and end of life decisions under the Mental Capacity Act - End of Life Care and DNACPR CRP decisions - Blanket policies to confine all care home residents to their rooms with no MCA / best interests and blanket DNACPRs - Blanket decision making DNACPR. Residents in care settings restricted to their bedrooms for long periods
Restrictive practices	- Advice to shielding people paternalistic view that people should never go out - Intro of concept of acceptance of capacitated decision based on understanding of risk and action to mitigate risks can lead to people feeling guilty & browbeaten into following shielding guidance - Have heard of situations where anxious carers are isolating people more than the rest of the population would be - Question of level of isolation within care homes - what is reasonable? "confined to barracks"? - Blanket restrictions in mental health units - Concerns about young people / care leavers when MH & MCA may be used to restrict the person for the purpose of public protection - Increasing restrictions without authorisation
Testing for **COVID-**19 when the individual lacks capacity	- Need to discuss testing people who lack the capacity - Have heard of blanket policies on testing in some care homes - The guidance on testing everyone in care homes and is consent and MCA taken into account in practice
Use of 'blanket' policies and approaches	- Hospital discharge has caused me to feel most uncomfortable. Also, blanket approaches - Have heard of blanket policies on testing in some care homes - Blanket restrictions in mental health units - Yes, blanket DNACPRs and end of life decisions under the Mental Capacity Act - Blanket policies to confine all care home residents to their rooms with no MCA / best interests and blanket DNACPRs - Blanket decision making DNACPR. Residents in care settings restricted to their bedrooms for long periods - Blanket restrictions on MH wards regarding visitors and not allowing leave - "Blanket" policies in care homes to restrict residents to their rooms

	• Making determinations about capacity without being able to fully engage P and blanket restrictions being put in place • Blanket decisions being made to keep asymptomatic residents in isolation in their bedrooms for 14 days • We hear from care homes that are carrying out blanket restrictions to their residents to protect them from spread
Other	• Detention of people with care needs instead of creative solutions • Difficult to assess balance the risk of COVID-19 if dol in hospital against risk if not • Not wrong but perhaps unrealistic expectations from family and other professionals involved • Impact of COVID-19 on social care • MCAs/safeguarding enquiries when video conferencing is not available or suitable and the care home is not facilitating visitors • I am unsure there is a balance to be had? People are consumed by the public health law • Generally as a regulator we are supporting all care providers and local authorities daily on such issues as this • Patients who are living alone are struggling with the social isolation • The government and society not prioritising the rights of vulnerable people in care homes • People with LD on at risk list but care/residential homes not included in swabbing programme • LD patients • Funeral arrangements • Wary of now over emphasis on homes, not enough on supported living (unregistered) • Yes - paper capacity assessments of people in care homes on the basis that capacity assessors ‘might’ infect residents • Concerns clients' social isolation, mental health and provision of safe care • Yes, with regard to Deprivation of Liberty • Making determinations about capacity without being able to fully engage P and blanket restrictions being put in place

Webinar 4 – September 9th, 2020

Taking Stock and Looking Forward

Registrants were prompted with the following questions:

What key mental capacity issues must be addressed for ongoing and future COVID-19 management?

Responses from registrants:[19]

---

[19] This table contains the responses of the first 350 registrants. Registrant responses are given in the right-hand column, and have been sorted according to theme, which is given in the left-hand column. Where responses can be further sub-divided, these sub-divisions have been listed underneath the relevant theme. Where one response covers

Theme	**Response**
Hospitals • Concerns that MCA is not being followed when patients are discharged from hospital into care homes (e.g. no capacity assessment) because of the need for rapid discharge	• When COVID-19 started, all visitors were banned from hospitals. Getting social care and IMCAs back into hospitals is essential • Shared understanding and alignment across health and social care. Especially in hospital settings • Care homes/hospital poor quality information on referrals • Capacity assessments at the point of discharge from hospital • The discharge of patients from hospitals into care homes should include MCA around that instead hasty discharge to assess later • The need to keep BI meetings / decision making without the COVID-19 rapid discharge from hospital being compromised • Lack of best interests meetings and formal capacity assessments when patients are being placed in care homes from hospital • Training for care and hospital staff • Assessments not being missed during hospital discharge processes • Ensuring social workers are involved in hospital discharge
Care homes • Concerns that restrictions imposed in care homes are / remain disproportionate, including: ○ Restrictions on visits from family ○ Separation of couples where one has tested positive for COVID-19 ○ Access to community • Concerns about blanket decisions within care homes • Concerns that the MCA is not being followed when testing takes place in care homes • Concerns that there is not enough support for care homes in terms of testing / treatment	• Maintaining human rights in care homes with the testing regime and the right to family life • A clear plan for managing care home residents must be in place at all times to meet the contingency of a pandemic going forwards • People should be enabled to consider the option of seeing family over just being safe in care homes • Communication and communication. Ensuring care homes and professionals have an efficient and secure way of sharing information • Support to care homes in testing and treatment escalation planning • Blanket MCA decisions in care homes • Care home visiting arrangements / restrictions • Issues re blanket restrictions - visits to individuals in care settings and access to community • Care homes/hospital poor quality information on referrals • Community access for residents; maintaining family contact; guidance and information to care homes and care organisations • PPE need for face to face contact in care homes • Monitoring of care homes' understanding with regards MC and testing, and restrictions being used, as visits not taken place. • Contact between couples in a care home when one is COVID-19 positive, role/ interplay of infection control & MCA • Overly restrictive practice by care homes (blanket decisions being made about visitors or residents going out) • Training for care and hospital staff

---

more than one theme, it may have been included in more than one section. Where multiple registrants raised the same issues (or very similar issues), some responses have been omitted.

<ins>Assessments and face-to-face contact</ins> • The need for face-to-face assessments to resume / concerns about the limitations of remote assessment • How to take all practicable steps / ensure all practicable steps are taken in the case of remote assessment • A need for training for staff who carry out remote assessments • The need for best-practice guidance in the case of remote assessment • Need for more technology within e.g. care homes to facilitate remote assessments • How to ensure that 'all practicable steps' have been taken in the case of remote assessment	• How to assess a person in a suitable manner without face-to-face contact • Assessing capacity with dementia patients when face to face is not possible • Online assessments skills for best interests assessors and social workers. Active support and participation from care homes to facilitate assessments • Whether remote assessment and triangulated paper-based assessments are proportionate in some cases • Training for staff to undertake capacity assessments remotely • When and who can do face to face capacity assessments. If family are shielding can carers undertake capacity assessments? IT? • Remote / video assessments are not suitable or adequate in many instances - skill up front-line staff instead? • To draw up best practice guidance in using remote assessment as an additional assessment tool • Having the right technology in place to assist with remote assessments, many barriers and lessons to learn • Need for best interests assessors and section 12 professionals to have face to face assessments as soon as practicable • Remote assessments. Impact of family and those who know someone well not being able to advocate for them in person • That capacity assessments aren't a 'tick box' exercise, they inform future care • Seeing people in person. So many assessments are being completed remotely which are poor in quality and result in bad decisions • The challenges faced with taking all practicable steps if a face to face assessment is not viable • Access to video conversations with clients • Communication via video/ phone contact • Individual assessment of capacity (should be taken as read but we still had 'group' decisions) • Access to P in order to gain views • Maximization of capacity and true assessment of capacity • Should remote/non face to face assessments end? And, not assessing face to face to protect the assessor rather than the client • Clarity on proportionality of assessments • Remote assessments and deprivation of liberty arrangements • When is a face to face visit essential? Without more guidance and examples, interpretation is highly subjective • Accuracy of assessments for long-term and impactful decisions especially for people who do not communicate verbally • Ensuring that "all practicable steps" have been taken in the case of remote assessment
<ins>End-of-life care</ins>	• How DoLS/LPS can assist patients at end of life in a meaningful way
<ins>Awareness and understanding of the MCA</ins> • Concerns that the principles of the MCA	• Ensuring people's rights are protected not ignored • The understanding of mental capacity and human rights for healthcare staff and the general public • It's the same issues as before: The principles of the MCA must be at the forefront of all decision-making

have been abandoned in the context of the pandemic • Concerns that there is a lack of knowledge / understanding of the MCA • When MCA and when MHA	• Issues around MCA in the community • How shallow the roots of MCA good practice are when placed under this pressure. MCA propriety was basically dumped • Stakeholders to know and understand what protections the MCA gives P during and after COVID-19 crisis • Right to advocacy still exists and referrals should be made • Compliance to the safeguards enshrined within the MCA • MCA principles!!! Different legal frameworks to support customers • Upskill all in MCA • Staff understanding of MCA and continued need in COVID-19 • That a pandemic shouldn't affect our rights to make our own decisions - and people still must be supported as per principle 2 • Better understanding of the principles • That practitioners are to evidence and document their decision making when using MCA • Using the principles correctly, understanding the individual and their needs, in the best interests • That assurance of informed consent is not a separate issue to MCA • Place of care and consideration of MCA in decision making is the key issue • Confidence on when MHA and MCA for inpatient settings
<u>Unwise decisions</u>	• The myth that people have the right to make an unwise decision as opposed to not being judged when they make an unwise choice
<u>Supported decision-making</u> • How to implement supported decision-making remotely • Supported decision-making in relation to COVID-19 risks	• Supported decision-making virtually • Supporting people to make decisions in the context of rules implemented by government • Supported decision making on returning to 'normal' life and the risks people choose to take now that lockdown is easing • Maximization of capacity and true assessment of capacity • what support can the providers/carers give to ensure that the capacity is maximised
<u>Best interests</u> • Concerns about whether the MCA is being followed in the case of COVID-19 testing in care homes / Best interest decisions in the case of COVID-19 testing • Confusion about whether COVID-19 testing constitutes ‘treatment’	• Best interests decisions on testing, where the person does not have capacity to consent to the test • Testing for people who have limited capacity to fully understand the process • Consent vs testing • Challenges in undertaking COVID-19 test for people who lacked mental capacity • Testing and vaccines • Robust capacity assessments despite lack of face to face Ensuring MCA/ best interests decisions used in testing policies • Testing for people who lack capacity • MCA assessments prior to swabbing patients in care homes without mental capacity • Is COVID-19 testing classed as "treatment" - Can this really be done in best interests? • Capacity around testing • MCA and declining the test for COVID-19 • All professionals to understand the difference between best interests and the persons wishes

<u>Restrictive practices</u>
- How to manage conflict between public health guidance and the MCA
  - In the case of risk to the individual
  - In the case of risk to others
- Concern that there is a ‘gap in the law’ when it comes to ‘isolating someone who lacks capacity in hospital whilst they have COVID-19, to protect others from infection’
- Concerns that restrictions may have a disproportionate impact on, for example, those with dementia, and concerns that this impact is not fully understood
- Emphasis on least restrictive option
- Need for clarity about which measures / restrictions are for the benefit of the individual, vs which measures are for the benefit of others
	- Contact with friends and families and when we should be relying on public health measures instead of the MCA
	- Managing the conflict between public health regulations and MCA DoLS. Providers struggle with individualised decisions
	- Gap in the law re isolating someone who lacks capacity in hospital whilst they have COVID to protect others from infection
	- To understand the impact to those with dementia who may not be aware of social distancing and the risk to themselves and others
	- Contact between couples in a care home when one is COVID 19 positive, role/ interplay of infection control & MCA
	- Least restrictive care management, whilst adhering to guidelines (PPE use, lockdown)
	- Possible restrictions to mental health service users experiencing acute episodes who are not capacitated to comply with COVID-19 restrictions
	- Supporting people to make decisions in the context of rules implemented by government
	- Responding to legislation, government guidance and the impact on patients
	- Issues under best interests and non-compliance of individuals with impaired capacity
	- Consent around isolation of symptoms and the person’s right to make the decision
	- Supported decision making on returning to 'normal' life and the risks people choose to take now that lockdown is easing
	- People who are 'walking with purpose' or 'wandering' who test COVID positive
	- LPS/DoLS re visitors, going out, testing. When distress turns in to trauma
	- Decision-making in relation to protection of others and PH law when it is primarily for the protection of others
	- Frontal lobe paradox in relation to COVID-19, unwise decisions and the law
	- Balance between protecting right to health with right to family, right to liberty, etc
	- Impact of restrictions and management thereof with those that have serious mental illness or cognitive impairment
	- Transparent clarity between individual best interests and public health requirements e.g. for anti-body testing and vaccines
	- Patients who lack capacity and enforced isolation pending COVID-19 test results or a positive test result
	- People’s right to make unwise choices balanced with managing risk in communal settings and for staffing
	- Section 47 of the MCA - least restrictive

<u>Miscellaneous</u> - Issues around fluctuating capacity - Advance statements	- Issues relating to fluctuating capacity in brain injury, executive issues and impulsivity - When to apply for DoLS - Objective and independent monitoring of decision-making, especially in domiciliary care - Supportive technology to aid communication with use of PPE - Professional/ legal responsibility for practitioners to comply with patients’ rights to involvement in the decisions made - Managing authority access to reliable virtual platforms

	- Education for all agencies of MCA - Systems working within health, a clearer allocation of responsibilities within the MCA forum - Raising the profile of service users' needs within our health services ensuring that they are represented in decision making - Specific role-related training - Having access to good quality information - Anticipatory care planning gathering wishes and feelings from person and fluctuating capacity - Individual assessment of capacity (should be taken as read but we still had 'group' decisions - Fluctuating capacity, reasonable adjustments - Digital Poverty - Fluctuating capacity - The availability if need be of a carer applying to be a Personal Welfare Deputy under s16 of the MCA - Informal 3rd party support arrangements - Advance statements re. consenting to be deprived of liberty under certain circumstances

From your experience, what lessons about the Deprivation of Liberty Safeguards (DoLS) in the pandemic should be incorporated in the new Liberty Protection Safeguards (LPS), when they replace DoLS?

Theme	**Response**
Hospitals - Improved transfer / discharge process	- Better transfer between acute and community setting - NHS understanding of MCA and DoLS. CCG awareness of MCA/DoLS for discharges from hospital. - Moving from one hospital site to another in the same Trust; DoLS teams requesting new application rather than ongoing review - Impact of rapid discharge processes in the pandemic
Care Homes - Work to ensure that the necessary documentation is sent across by the care home - Work closely with care homes to avoid blanket decisions and overly restrictive practices	- Care homes (and other settings) being specific in asking questions about a potential resident's capacity - How can we work in closer collaboration with care homes and support in relation to testing, visiting and freedom of movement? - The care home's role in relation to LPS and during the epidemic the information the providers are sending are poor - Consideration of "all home testing" how this is taken literally - A basic requirement for care homes to use the MCA when setting up COVD related policies - Care home staff to be given more understanding about Dols/restrictions. Flexibility about the responsibilities of RPR - The limits that need to be in place regarding care homes' powers under LPS - Blanket DNACPR's for nursing homes
Assessments and face-to-face contact	- Some assessments are working remotely but this should not be the norm - The ability to rely on previous information if there is no change. - Creative assessment

• Continue with remote assessments where appropriate • Return to face-to-face assessments where remote assessment is not possible / suitable • Guidance needed on how best to conduct remote assessments • Continued use of equivalent assessments where appropriate	• Ability to assess remotely / proportionately • Importance of face to face contact must not be lost with over reliance on desk top exercises & advance care planning • Remote & desk top ask is not for everyone!! Whilst good, we also need to pick up on areas where it doesn't • No blanket policy on the use of remote assessments, but should be decided on a case by case basis. Care home managers should not be responsible for making assessment arrangements; reliance on previous assessments concerns • Robustness of remote assessments and justification • Using past relevant assessments. A listing of documents required from care homes that will contribute to LPS' determination. • Valid equivalent assessments • Use and misuse of previous assessments. Impact of non-face to face assessments – clear examples of good practice in remote assessments • That remote assessment can in some cases be more effective that face to face if properly done • Good practice issues with regards face to face assessments and video-link assessments. The current guidance too • Doing as assessment in a variety of ways – part by telephone, part video, part visit as appropriate but not default video • The appropriate use of remote assessment/ triangulation when looking at fewer complex cases within LPS - though not to be default! • Use of creativity and multi-agency partnership working, remote assessments vs face to face • To be able to use professional judgement in that not all cases need to be seen/visited. Some still can be remotely assessed • Use of equivalent assessments, especially for diagnosis when someone has a lifelong or permanent impairment of cognition. • Use of video assessments for DoLS • Access, by any means, to the adult. • When patients get distressed from numerous assessments – a desktop assessment should be permitted, providing certain criteria [are met] • Remote consultation • ensuring consultation with carers/family by using virtual consultations – thinking outside the box • Alternative communication approach i.e., phone or video can suit some people more and illicit better engagement • Electronic forms / remote 'virtual' assessments • Blended assessments • How to assess and decide on BI when not possible to visit P
<u>Need for Training</u>	• Wider education across public and private sectors • Need a competent workforce as LPS will put greater responsibilities on provider organisations, CCG and front-line professionals • It should be made statutory & mandatory for professional staff to be fully compliant with MCA training • Better national guidance on LPS and greater buy in by service user and carer groups • Greater awareness & training in all parts of health & social care

	• The need for greater understanding and knowledge in the provider sector in relation to MCA and deprivation of liberty • Concern about some hoe managers understanding of MCA
Restrictions and Managing Risk • Clarification on the legality of restrictions made for public health reasons / safety of others • A requirement that the rights of the individual be taken into account where restrictions are imposed • Article 8 rights	• The need to ensure people's human rights are upheld - they are not negotiable even in a pandemic • I think more about rights to residual liberty (such as seeing your family) considered separately and additionally • The ongoing limitations on family contact, remembering P's rights to a family life (Article 8) and facilitating family contact • Assessment process, increased restrictions, consent to testing, Article 8 Rights • Protection of others needs to be included • Issues relating to impulsivity, risks, lack of insight and realistic management in the community • Embedding restriction identification into support plans/care plans as part of discharge arrangements • Emphasis on evidencing why certain restrictions are being imposed backed up with proper capacity assessments and recorded best • The necessity of restricting liberty of some individuals via least restrictive care regime in their own home • The need for ongoing review of the mental health and the implications of any restrictions by section 12 approved doctors • Something around isolating residents in their rooms in care homes and if this is acceptable as part of DoLS • Assessment process, increased restrictions, consent to testing, Article 8 Rights • A basic requirement for care homes to use the MCA when setting up COVID-19 related policies • Clarifying use of MCA on responsible citizen grounds when its more risk to others than to self • Should LPS cover detention for the safety of others? • how to maintain social distance and safety when managing challenged deprivations • Additional restrictions re 14 days isolation for care home admissions and what this isolation period entails • Explore families' right to visit service user in care home under DoLS relating to pandemic protocols
Suggestions for changes	• Extended definition of life saving treatment to be retained • Greater emphasis on human rights legislation • The availability if need be of a carer applying to be a personal welfare deputy under section 16 of the MCA • Additional monitoring / safeguards where greater restrictions had to be placed on people who lack capacity during the pandemic • External scrutiny from independent BIA to ensure persons wishes are not overlooked • That where possible 2 MC assessments are carried out i.e. 1 independent professional • Independence of assessor as a double check to the answer to question one. Proper and adequate assessments using other methods rather than face to face

<u>Need for further guidance / clarity</u> • Clarification on the legality of restrictions made for public health reasons / safety of others	• Guidance around what constitutes a restriction, firm guidance on self-funders in care homes, re-use of mental health assessments • A definition of deprivation of liberty should be included in the code to address what life saving interventions are excluded • We need clarity on what a deprivation is • Clarifying use of MCA on responsible citizen grounds when its more risk to others than to self • How to deal with objections in a lockdown situation • clear examples of good practice in remote assessments • COVID-19 has taken liberty away from older adults, especially those with dementia. Greater clarification is required. • Definition of a capacity hierarchy considering COVID-19 restrictions • Absolute clarity on how far the Ferreira judgment goes regarding usual care and treatment • Something around isolating residents in their rooms care homes and if this is acceptable as part of DoLS • Clarifying use of DoLS as opposed to Section2/ 3 MHA for AMHPS and consultants • We need unambiguous instructions from government on LPS implementation (including cost, exemplars of assessments)
<u>Practicalities</u> • A need for shorter / more straightforward / more user-friendly paperwork • Improved systems to allow for the secure transfer / sharing of documentation / information electronically	• Court of Protection forms. A Word document which when finalised could be emailed as a pdf would be helpful. • The use of short forms so that staff are able to compete the LPS in timely manner • That managing authorities need a structured tool to assist them in carrying out meaningful assessments of mental capacity • Information sharing – we need better systems for sharing information, e.g. care homes sending care plans electronically • Electronic sharing of documents. Focussing on P during visits/comms. Care homes may not be the safest place. • Shorter forms and streamlined remote court based on case by case • Shorter and easier to use form • Agreed secure transfer of associated records between organisations • Making sure its LPS is more streamlined making the system more smoothly making sure all views are considered • Safe transfer of information electronically • Streamlined information in undertaking the BIA assessments • DoLS application form should remain and not change as it caused double work as staff had been asked to complete form 1 as well • The nature or reports required to authorise, the focus on embedding correct MCA practice across social care workforce. • Simple paperwork • Proportionate paperwork • Speedier court response times • There is a need for proportionality in ‘paperwork’. Some key information has not been made available in shortened form.
<u>Other</u> • Greater need for advocacy	• The ongoing importance of person centred/skilled advocacy services • Adequate resourcing to both implement the safeguards and to provide assessors and staff to correctly manage the scheme

	- The requirement to use professional judgement about how the DoLS can add value to a patient's care at end of life - Extended period of transition for newly appointed supervisory bodies - How to deal with objections in a lockdown situation - MCA completed by people not regulated by a professional body is going to jeopardise quality, and implementation - Transferring authorisation - Greater emphasis on the role of carers/ family/ advocates in decision making - The roles and responsibilities of professionals including trust directors, ward staff and AMCP. Managing objections. - Pre-planning guidance, S21a have increased due to lack of choice of placement during pandemic, something around contingency plan - Individualised decision making remains - SLT & advocacy skills/support will be needed more than ever & thought is needed about how best to involve them routinely - There is still a legal requirement even in a pandemic - Emergency applications don't necessary require a long-term deprivation - Fluctuating capacity/review of DoL promptly/care home management of people with Dols/fluctuating capacity - A review of if DoLS was recorded and reported accordingly to local authorities. I would expect to see an increase and DoLS - the principle of decision making for the individual - Support for adults at risk within the wider community setting - Reviews should be frequent - The state still has to safeguard people's rights even at times of pandemic - The need to ensure all support is put in place, even remotely - Being creative and flexible in your approach and in care plans - Looking at individual needs in a holistic manner- like you would in a best interests decision - Ensuring these can be quickly reviewed and adapted - The issue around life sustaining treatment. / physical impairment - DNACPR and ReSPECT forms must be completed in advance

Drawing on your experience of the pandemic, which issues need additional guidance in the revised MCA Code of Practice?

Theme	**Response**
Assessments - Guidance on when remote assessments might be appropriate - Guidance on how to best carry out remote assessments	- Again, without face to face contact it is really difficult to assess somebody with communication difficulties - More guidance on triangulation of evidence in mental capacity - Extent to which we can rely on third party MCA assessments, ask people to assess capacity on our behalf - Use of video calling, how do we ensure that people's human rights are upheld when we cannot see the environment where they are

• Guidance on the use of third-party capacity assessments • Clarity about which documents can be used for assessments • Development of a tool to aid assessment • Reminder of the first principle of the MCA • How to assess capacity for decisions around COVID-19 testing • Clarity around what can be expected of care homes in terms of access and documentation • Clarity around who is responsible for assessing capacity	• Need to be clear on timescales for assessments and what types of documents can be used • Possibly to incorporate a structured tool to assist practitioners with mental capacity assessments. • Remote capacity assessments/involvement of others/technology • The first principle of the MCA • Assessing capacity and extent of reliance MCA s5 rather than jumping straight to urgent DoLS authorisation • CoP needs specific reference to remote assessments to give confidence to others that these are 'valid' • Who should assess capacity - roles and boundaries. Best interest in practice - How do you check - how it applies • Remote assessments, timescales are much more challenging • How to actually carry out and record capacity assessments and best interests decisions when implementing national restrictions • Quality of capacity assessments • Assessing Mental Capacity - who is responsible? • Video-link assessments. Proportionality of assessments. • Remote assessments methods need to be considered where they support someone not just because it is cheaper or more convenient • Approval of remote assessments as a standard for some assessments • Capacity assessment protocol in light of COVID-19 restrictions • Sharing information securely, care homes need access to the internet and secure mail systems in place. • how to effectively assess patients for mental capacity for swabbing • Assessments from a distance and using technology, how to make an LPA/ADRT during a pandemic, and no blanket DNACPR • When and why non face to face assessments might be appropriate • What level of co-operation can AMCPs expect from care homes, assessing remotely. Can we expect video? Care files emailed?
<u>Supported decision-making</u>	• Best practice on remote assessments as additional tool. More guidance on supporting decision making re Principle 2 • Impact of COVID-19 upon routine engagement/facilitation of autonomy in services may be significant - CoP will need to address • Supported decision making - this has not been done consistently well
<u>Unwise decisions</u>	• The importance of adhering to principle 3, and importance of respecting capacitous decision-making
<u>Best interests</u> • Defining ‘best interest’ – in particular, whether / how to incorporate risk to others • What constitutes medical treatment for the purposes of the MCA	• Where decisions made are due to the need to protect others - when should you apply to Court of Protection • Guidance to managing authorities on facilitating remote assessment. The legal powers where harm to others is primary • Best interests definition • The importance of focussing in on the wishes, feelings and beliefs of the RP • MCA and medical treatment need to be more specific; I have worried about testing for COVID-19 with those who lack capacity to agree

(e.g. does COVID-19 testing constitute treatment?) • Determining best interests remotely	• Views of the person • Who should assess capacity - roles and boundaries. Best interests in practice - How do you check - how it applies, how it is • How to actually carry out and record capacity assessments and best interests decisions when implementing national restrictions • Testing - BI • Wariness of public health encouraging 'whole home' approaches to testing - issues around consent and using MCA/BID • The weight to place on people's views and wishes • MCA goes beyond to include PHE guidance in respect of residence. Reasonably ascertainable principle. Best interests. Risk Assess. • Social distancing for those unable to understand and best interest and restraint for this • The use of the Ferreira case in decision making re life sustaining treatment & vital acts • How BIAs gather views when they cannot physically meet with P • Public health law versus MCA best interests
<u>Restrictive practices</u> • How to reconcile public health law with the MCA (‘which takes precedence?’)	• Checklists to ensure people's rights are considered and protected • isolation of people who are incapable of understanding the reasons for isolating and impact on the wider community. • interface between public health law and MCA • Visiting and meeting people face to face. Also, family visits being facilitated in safe ways. Locked down not locked in • Clarity to better inform risk assessment around whether DoLS becomes relevant and appropriateness of a virtual assessment • Deprivation of liberty to enforce COVID-19 restrictions e.g. isolation- legal basis • Clarity on what can be done if supervisors don’t complete DoLS assessments • Clear guidance linked to 'mandatory' requirements like swabbing and MCA- which takes precedence • MCA goes beyond to include PHE guidance in respect of residence. Reasonably ascertainable principle. Best interests. Risk asses • Discharge planning and government advice over COVID-19 not congruent with MCA and the persons best interests • Family unable to meet other family members in care homes especially towards end of life as a result of COVID-19 • Support around visiting in care homes, in order that residents do not become more discriminated against in the name of protection • Social distancing for those unable to understand and best interests and restraint for this • People who lack capacity and not able to follow social distancing • How to address and take into account and balance PH statute and law/ MCA and the HRA when making decisions • Use of MCA in restrictive practices. When to use MCA • When public protection orders will supersede MCA • Management and monitoring of restrictions placed on people who lack capacity, e.g.: periods of enforced isolation • Public health law versus MCA best interests • Advice on how to safely implement and review DoLS during further pandemics when access to individuals might be limited

Interface between MCA and MHA	• Interface between MCA and MHA • More clarity required on the interface between the MCA and the MHA
Roles and responsibilities	• Fluctuating capacity, role of LPAs and how to properly challenge decisions thought to not be in the RP's best interests • Clarification of who assesses patients for DoLS since there will be no best interests assessors • OPG role particularly where concerns about an LPA for health and welfare • The role of the advocate • Assessing mental capacity - who is responsible? • When Court is required, MCA principles, creativity, risk of harm to others • When it is necessary to refer to IMCA • Clarity about 'who' is decision maker' and the limits of LPA for health and welfare i.e. the need to still follow MCA code and act in P's best interests. • Advanced decision to refuse treatment and LPA role for health and welfare re decision-making in the best interests of P • Criteria for RPR (visiting care homes is difficult)
Advance planning	• Drawing up and lawful use of DNACPRs/ReSPECT • DNACPR and consultation. Support required for informed decision making • DNACPRs • Clarity and transparency with DNACPR decisions to reflect consultation P (views and wishes) and interested persons • Guidance on advance care planning- to encourage care homes to record advance statements of care with capacitous people • Assessments from a distance and using technology, how to make an LPA/ADRT during a pandemic, and no blanket DNACPR • DNACPR. Approach to objection. Meaning of "un-befriended" and IMCA appointment • Advance statements consenting to be deprived of liberty • Serious medical treatment - what this means for access to healthcare (or not) - DNACPRs/decisions about end of life • Advance decision to refuse treatment and LPA role for health and welfare re decision-making in the best interests of P
Hospitals and healthcare providers	• Temporary transfer/restrictions for example people were discharged to care homes to reduce hospital stay • Focus on medical staff training by providing more case scenarios The GMC & HEE must commit to deliver training & revalidation • Discharge planning and government advice over COVID-19 not congruent with MCA and the persons best interests • Recording of MCA in hospital settings • Ensuring that the principles are adhered to in health settings • Applications in hospital setting. Definition of life saving treatment. COVID-19 swabbing
Other • Fluctuating capacity • Article 8 issues	• Issues of fluctuating capacity, lack of insight, executive problems for clients and the same issues in relation to professional • There are many but one is the overlap of health and welfare and property and affairs matters

	• Ongoing training on capacity, supported decision making, consent and when best interests decisions are required • Addressing capacity issues in homes • The mental health aspect of coming out of isolation (shielding) which is in my experience affecting people significantly • About younger people 16-17 • Depressingly very, very basic reminders about what human rights mean • All stakeholders need to have greater knowledge of the codes of practice and their responsibilities to implement • Ordinary residence • Appointment of more professional welfare deputies • Concerned about long-term impact of lockdown/COVID-19 on those who lack capacity (progressive cognitive decline, behaviours, etc) • MCA and social media/use of video and communication - yardsticks of good practice in new areas • Interim decisions • Keeping MCA principles at the heart of our decision-making in those without MCA even in times of COVID-19 • Case studies to cover a variety of job roles • Testing prior to procedures • Temporary ACPs during time of pandemic • Article 8 issues - contact arrangements - remote capacity assessments • Fluctuating capacity due to physical illness • Unprecedented circumstances, needs a section • Period of authorisation • Clear guidance on salient factors - especially in relation to COVID-19 and other infectious diseases • Isolation • Clarity on where the MCA fits in with the pandemic and its impact on choice and consent • Professionals still lack the understand of the principles and how to use them and best interests at all levels • The routine everyday nature of application of the MCA • When service users who need to return home for end of life care • Fluctuating capacity and executive functioning • How the risk posed by COVID-19 transmission can be balanced with people’s rights? • The current CoP does not cover the darker side of mental capacity - e.g. scams and abuse

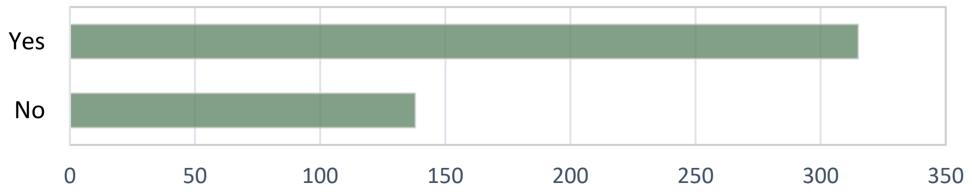
Webinar 5 – November 11th, 2020

The MCA and the Messy Reality of COVID-19

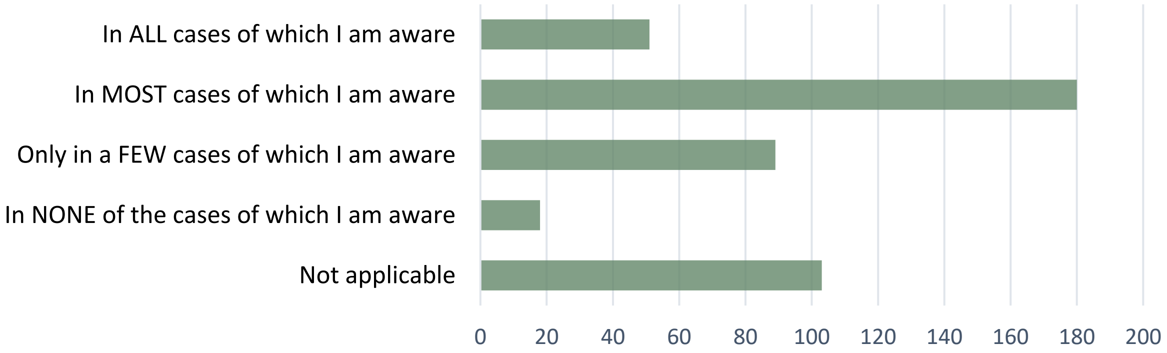
Participants were asked about:

- “Do Not Attempt Cardio-Pulmonary Resuscitation” (DNACPR) orders;
- DHSC guidance on visits to care homes during the pandemic;
- the transition from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS), and what should Government focus on in preparing for this transition.

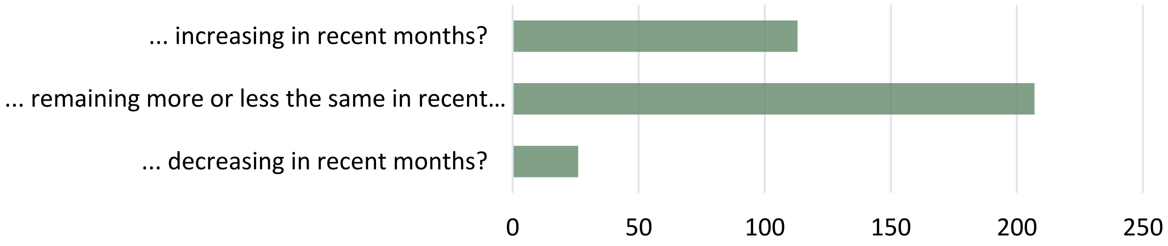
During the pandemic, have you seen the terms "DNR," "DNAR," and "DNACPR" used interchangeably?



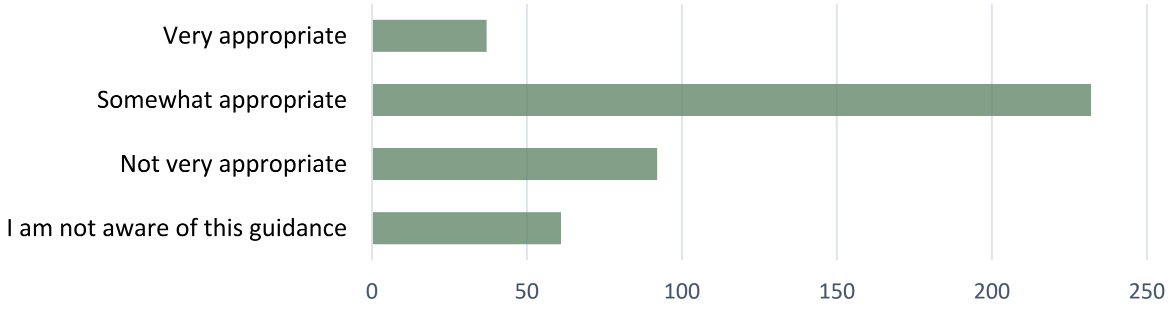
In your experience, was the patient and/or their family consulted before a DNR/DNAR/DNACPR decision was made?



Have you seen DNACPR orders written without individualised consultation...



How appropriate have you found the DHSC guidance on visitors to care homes during the pandemic?



From your experience, what are you most concerned about in the planned transition from DoLS to LPS?

Need for training & support

- Preparing and training the workforce to comply with the changes
- The resource and guidance to support professionals to make the transition
- Upskilling all staff in managing authorities
- Having early access to the code of practice and good quality training for the transition
- In the acute hospital setting, staff knowledge and competence in use of Mental Capacity Act
- The breadth of training required across all sectors for those who have minimal or no practical knowledge of the MCA
- Making sure people have the relevant training to enable them to fulfil their roles under LPS
- Confusion it will cause care providers in terms of lack of understanding of their change in role and responsibilities
- Lack of knowledge regarding the MCA and deprivation of liberty at present and how this is going to translate in the future
- Lack of skilled staff to perform the role
- Workforce readiness
- Training / skills input from care home providers for care home managers
- Front line staff grasping the intricacies of deprivations of liberty vs restrictions and applying the knowledge to practice
- Legal literacy of practitioners
- Sufficient training for the changed role of best interests assessors
- Staff understanding of the process and application and recording
- Sufficient training for assessors within acute trusts
- Ensuring the care homes have a good understanding and are able to complete the work required
- Knowledge of MCA in ensuring that people's human rights are protected
- Levels of knowledge and confidence in social care staff outside of the pre-existing 'DoLS' teams
- There are substantial qualified best interests assessors who haven’t practised for a number of years- how will they transition to AMCPs?
- Making sure that systems are in place to support service users and providers

Need for resources

- The resource and guidance to support professionals to make the transition
- Funding for advocates, training
- Funding to support implementation
- Resource implication for acute trusts
- The impact assessment does not reflect the additional costs of advocacy or the impact on local authorities
- Lack of resources. Workforce shortages if only qualified workers are allowed to conduct capacity assessments. court costs

- Potential costs to new responsible bodies (non LA)
- Resources for increased numbers eligible for LPS

Timing

Delays and preparation time

- Not finding the time to train
- Lack of funding for resources and time to transition
- The delay to the transition
- There will continue to be delays in publication of the regulations and Code of Practice
- Time delay to the publication of the Code of Practice and Regulations alongside delay in the revised impact assessment
- Will the Code of Practice and regulations be published with sufficient time to allow proper consultation, full assimilation and roll-out
- That it will be rushed and not be as fit for purpose as it should be
- The time to do so. The other ASC teams being ready.
- That local authorities will leave everything to the last minute and that that MCA is still not embedded in practice

COVID-19 context

- The lack of preparedness from NHS providers and care providers due to the ongoing and pressing priorities around COVID-19
- Applying the principles during COVID-19 pandemic
- Timescales - second / third wave COVID-19 continuing to require significant resources and trying to fit LPS into the mix

DoLS backlog

- The backlog of DoLS applications on behalf of the CCG and the lack of staff understanding the importance of completing these now
- DoLS waiting list and what to do about it

Increased workload

- Managing authorities being able to deal with their obligations
- Increased responsibility and demand on care homes
- CCG's ability to meet their requirements. The sheer volume of assessments as all models of care will come under umbrella of LPS
- Front line social care teams not being aware / prepared for the significant role they will now play in carrying out assessments
- Will the process be more complex? Will the paperwork be more complex?
- Adapting to a new process, paperwork etc and the added responsibility of being able to self-authorise
- The system is not less autocratic than DoLS, more so for health services
- Managing the infodemic and having in place all the strategy documents in time for compliance deadlines

Lack of independent scrutiny

Due to devolved responsibility

- Lack of independent assessments

- The fact that managing authorities are expected to manage/assess/authorise their DoL for their residents/patients
- Independent scrutiny of care homes, self-funders, who will be doing the assessments where there is not the need for AMCP?
- The care homes having a say on whether they think a person needs an advocate or not
- Conflict of interest with the managing authorities doing assessment
- That, as with DoLS, local authorities will have too much discretion with funding and processes, leading to inequitable roll-out
- I am worried about oversight

Due to inadequate safeguards

- Lack of Independent scrutiny/safeguards and people being missed
- That not everyone person will have advocacy support
- That those eligible for advocacy may be overlooked
- AMCP only for "objecting" residents Advocacy is now a best interests decision
- The loss of the RPR role
- Objecting patients not having access to right of appeal
- The potential downplaying of the safeguards and role of the AMCP
- Objections not being acted on or even identified
- Lack of independent safeguards
- The effectiveness of the role of Appropriate Person (AP), as opposed to the current RPR role
- Lack of best interests focus
- Lack of IMCA involvement and too much responsibility given to care home managers
- That we will be dependent on fairly inexperienced carers to determine if a person is objecting in a paternalistic society
- Ensuring human rights are protected
- Reduced protection for those without capacity

Lack of clarity

- The continued lack of detail
- Currently the lack of information regarding the Code of Practice
- Lack of clarity over the role & responsibilities of care home managers
- Confusion of front-line staff. Inconsistencies between LAs
- Clarity - guidance around how this will be fully integrated in practice across adults and children's services
- Lack of clarity as to who is going to do the medical assessments
- The assessment is very vague and non-personal

Other concerns: impact on children, inclusion, communication, implementation

- The inclusion of children from 16 years and the impact on services
- That information changes will be "cascaded" to the relevant parties when in reality silo working is still cause for concern
- LPS is a much-streamlined process - so some individuals who would have had the safeguards provided by DoLS will fall outside
- Patient involvement
- Level of communication of changes to relatives and staff
- Communication of the changes and them being understood
- Local implementation and a co-ordinated approach
- Lack of information and consistency in practice
- The risk of a 'gap' as we transition, of duplicating bureaucratic bottlenecks & under-involvement of communication specialists
- We already tried it temporarily in Jersey and spotted many practical problems
- Poorly worked through guidance that doesn't address the problems with DoLS

From your experience, what should the Government focus on in designing the planned transition from DoLS to LPS?

Clear guidance and communication

- A universally simple and accessible guidance and information, which can be understood and applied to day-to-day practice
- Publish impact assessment/Code/regulations ASAP
- Clear communication and cascading
- Be clear from the onset about who will take responsibility for what and how organisations can work to support each other
- Clear messages to all NHS Directors and their role in LPS

Resources

- Ensuring that all relevant parties have funding to train staff and implement the new changes
- Providing a realistic cost analysis and resourcing local authorities appropriately
- Funding to be provided to ensure that backlogs are dealt with prior to the transition
- Funding for advocates
- Training/funding for care homes who will implement the safeguards despite care homes right now still struggling to und DOLS
- Funding for local authorities and CCGs
- ensuring there are enough funds and enough AMCP in post
- Ensuring there is enough provision for people to access independent advocacy
- More practice

Training and support

- Proper training for all health, social care, and the private sector
- Training on how to complete LPS and training around the new code of practice
- Training social care staff in identifying restrictions when completing assessments
- A raft of mandatory training to ensure the whole sector workforce has a good practical understanding of the MCA.
- Training for all social care staff who do not really understand DoLS now (aren't best interests assessor trained) and are not aware of LPS
- Training, in particular to care home management
- There needs to be a focussed approach to how we train staff and how we get them onboard with the process
- Ensuring all supervisory bodies have the relevant training, skills and knowledge
- identifying the level of training and skills required in the creation of new roles
- Supporting organisations to implement the changes, i.e. what they should be doing and how they should be doing it
- Supporting managing authorities to understand their role in ensuring that people are not deprive of their liberty unlawfully

Protecting P and P’s rights

- Ensuring that it is still person centred and people have a voice
- The individual’s safety. Well-being and the least restrictive option
- Ensuring person remains prime focus
- Ensuring P's human rights can be properly protected
- Ensuring P is assessed by someone independent where there is no conflict of interest
- The import of really reflecting a person’s wishes, interrogating what they want as opposed to making assumptions
- Individuals’ rights to advocacy and accessing this
- Independent support for P

- Ensuring liberty is properly protected, not just simplifying legislation
- That everyone who should be under DoLS continues to be picked up under LPS

Standardisation

- Nationwide consistent guidance
- There should be a standard and consistent approach by all
- Unified structure across the county - not localised versions.
- Standardised forms, every trust and local authority uses the same documentation
- Standardised MCA and best interests templates, MCA policies etc to implement
- Standardised training or an eLearning and standard national forms

Ensuring scrutiny

- Independent oversight
- Monitoring compliance.
- Organisational accountability
- Ensuring process is not open to abuse
- Training - all staff need a recognised qualification that holds sanctions if MCA is not applied correctly
- Ensuring P is assessed by someone independent where there is no conflict of interest
- AMCP need teeth rather than being a tick off process
- Ensuring that there is adequate scrutiny of decision making around DoLS
- Adequate safeguards that prevent malpractice and unlawful degrading or unnecessary restraint
- Independence, independent assessor to see people

Information and awareness spreading

- Information should be clear, concise and understandable for everyone
- Public awareness- for this to work families and friends need to understand the process
- Having champions in place to promote awareness
- Ensuring all affected parties have received sufficient information to understand how the changes will affect them
- Clear information for P and families

Consulting stakeholders

- Ensuring advocates and organisations can contribute meaningfully to the development of the Code of Practice
- Consultation with the people who carry out and supervise assessments
- Listen to expressed concerns from all groups
- To share and consult widely as different local authorities have different set-ups
- Seeking input from all professionals
- Openness to feedback in the consultation on the LPS code and regulations
- Speak to people on the front line to help shape policy and guidance
- Speaking with those involved in DoLs i.e. frontline workers and their teams

Limiting bureaucracy

- Making this a meaningful process rather than a tick box exercise
- Less bureaucratic process for authorisation
- Cut down on paperwork - focus on outcomes

Other: Simplicity, timing, implementation, inadequacy

Simplifying the application of LPS

- Streamlining the process and building it into process for admissions to placements
- Making the process more streamlined to avoid 'gaps'
- Realistically factoring in a timescale for addressing backlogs as part of the transition
- Needs to have enough time and resource to implement properly
- How computer systems will need to be adapted to record and monitor LPS
- Do a ‘U-turn’ and think of a better plan

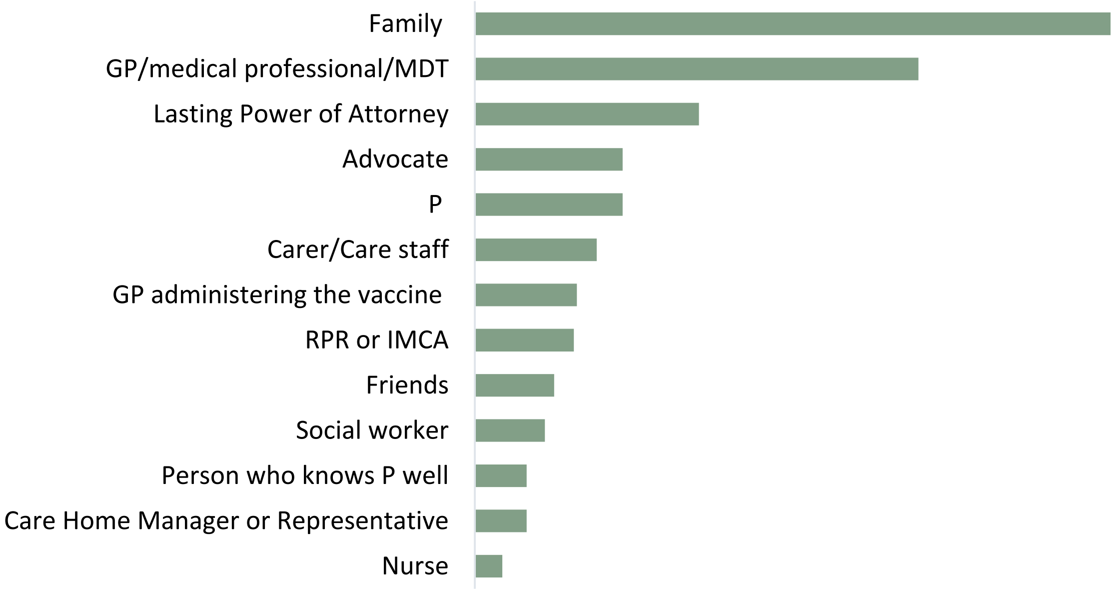
Webinar 6 – December 18th, 2020

The MCA and COVID-19 Vaccinations in Care Homes

Participants were asked about issues surrounding consent, capacity, and best interests in the context of COVID-19 vaccinations.

How confident are you about applying the Mental Capacity Act in making best interest decisions?

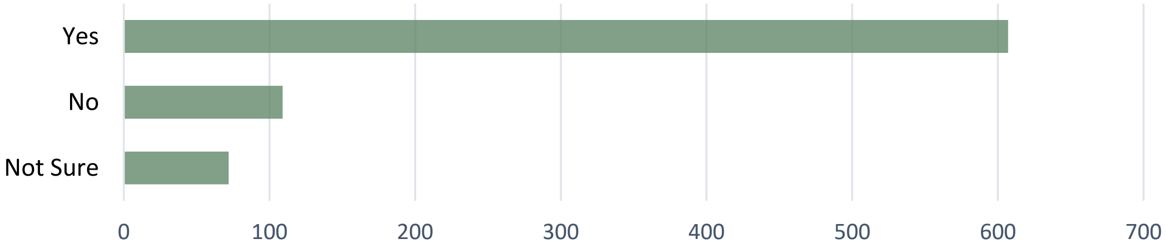
The chart below shows an overview of the most commonly mentioned themes and gives a relative indication of how often they were mentioned.



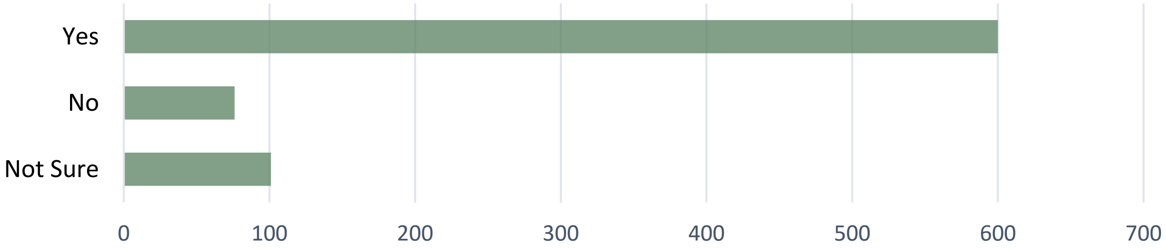
Please suggest a simple way to support someone with cognitive impairment to decide about having COVID-19 vaccination.

The chart below shows an overview of the most commonly mentioned themes and gives a relative indication of how often they were mentioned.

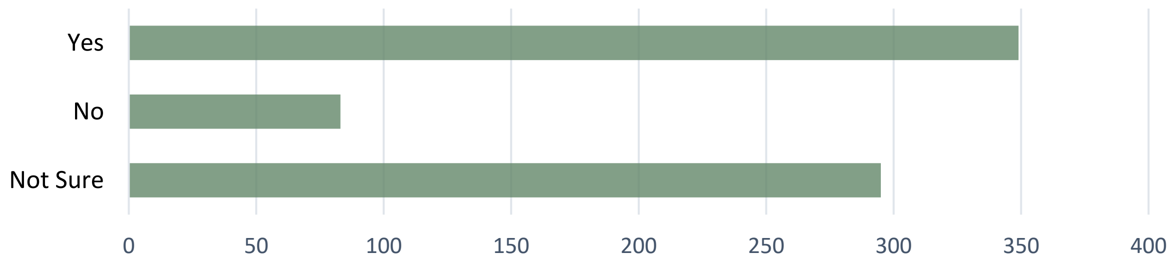
Do you have to assess capacity before giving a COVID-19 vaccination?



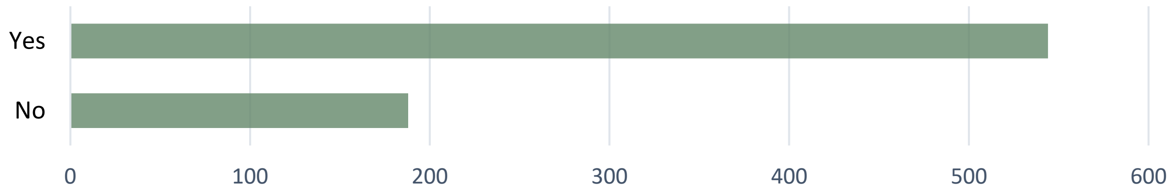
Is a best-interests meeting required if a patient lacks capacity to consent to a COVID-19 vaccination?



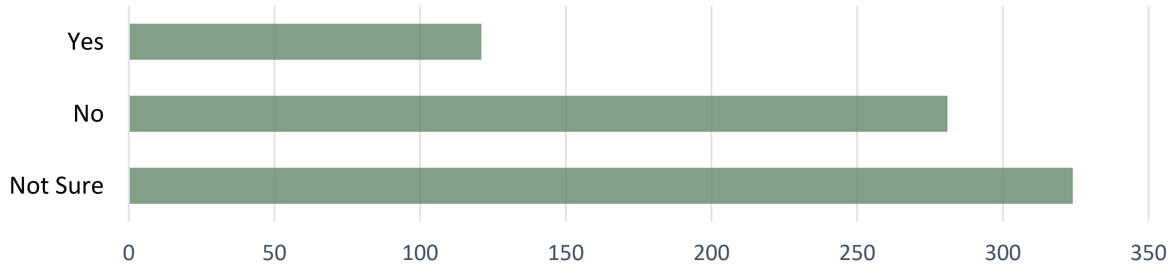
Can a court-appointed deputy consent to a COVID-19 vaccination for a patient who lacks such capacity?



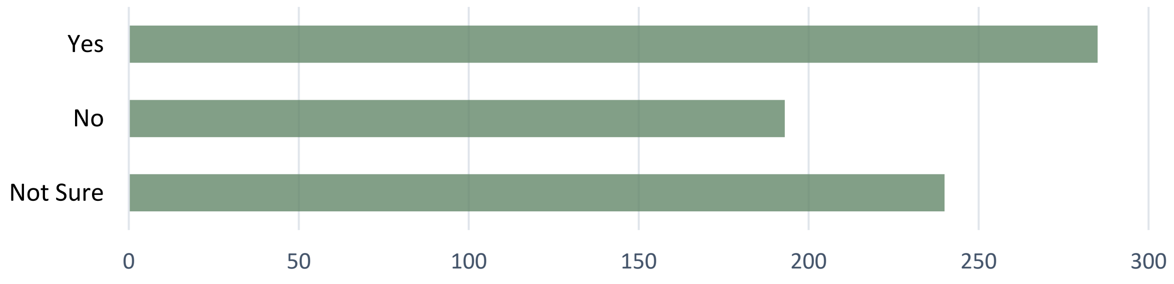
Do you know how to check whether an LPA (Lasting Power of Attorney) is valid?



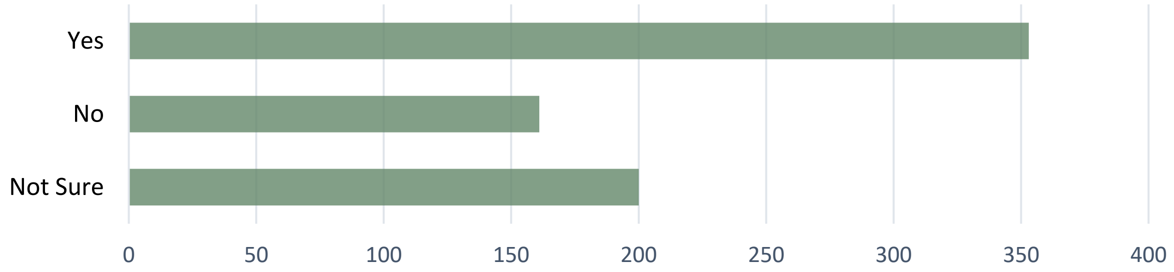
If an attorney for health and welfare refuses consent for the person they represent, can you still give a COVID-19 vaccination in the person’s best interests?



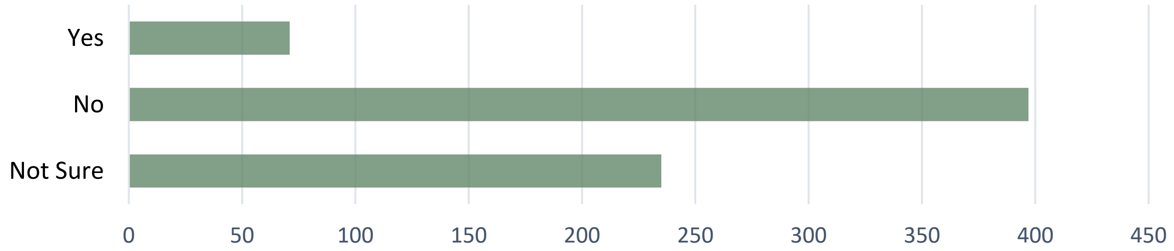
Is consent to a COVID-19 vaccination valid without a signed form?



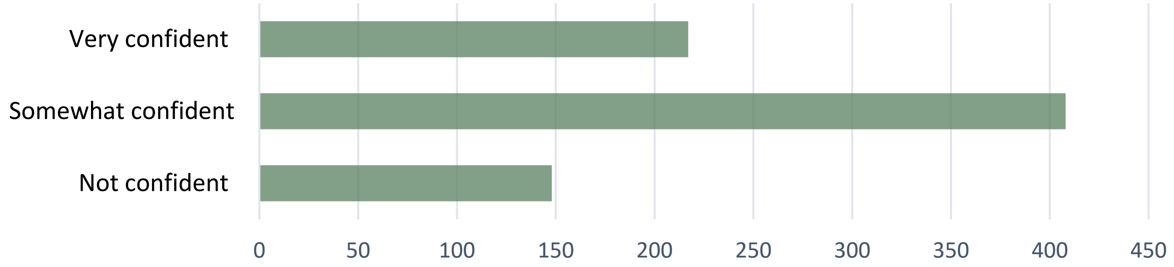
If restraint is needed to give a COVID-19 vaccination, would a DoLS assessment be required?



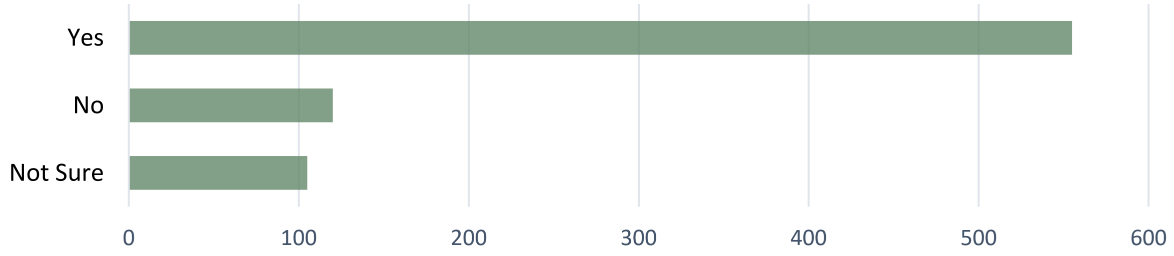
Is it appropriate to offer a sweet or chocolate as a reward for vaccination?



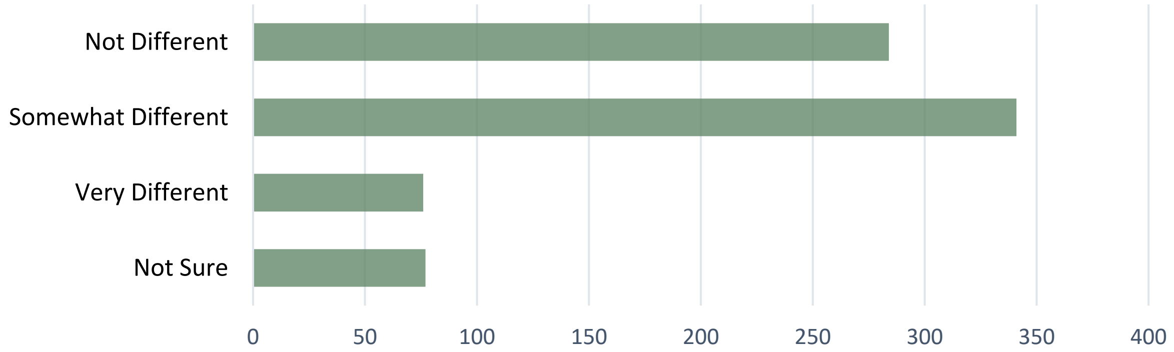
How confident are you in determining a person's capacity to agree to a COVID-19 vaccination?



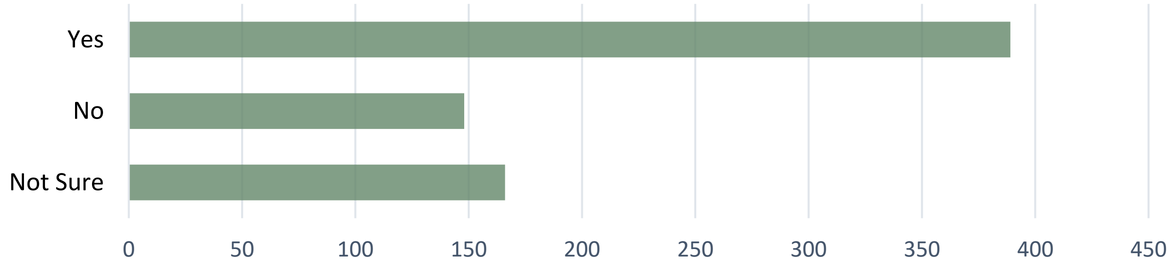
Do you know where to find the latest government guidance on giving COVID-19 vaccinations?



Is consent to COVID-19 vaccinations substantially different from consent to flu vaccinations?



Is lack of capacity a major challenge for COVID-19 vaccinations?



Webinar 7 – January 21st, 2021

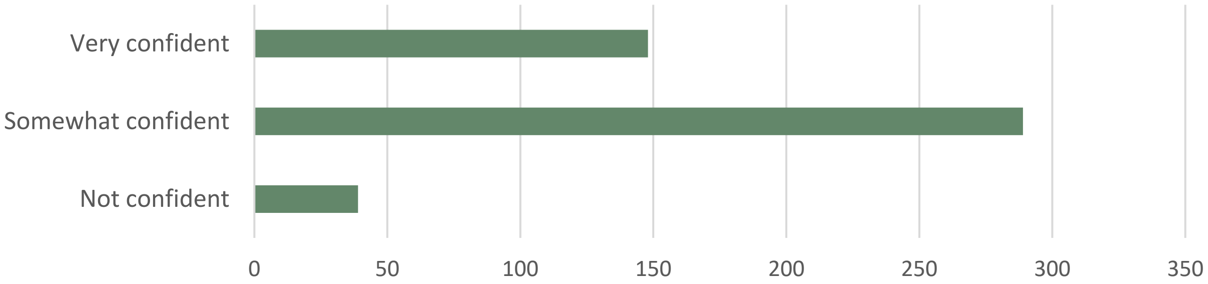
Best interests decisions: supporting primary care in difficult times

Participants were asked about the following issues in the context of best interests assessments[20]:

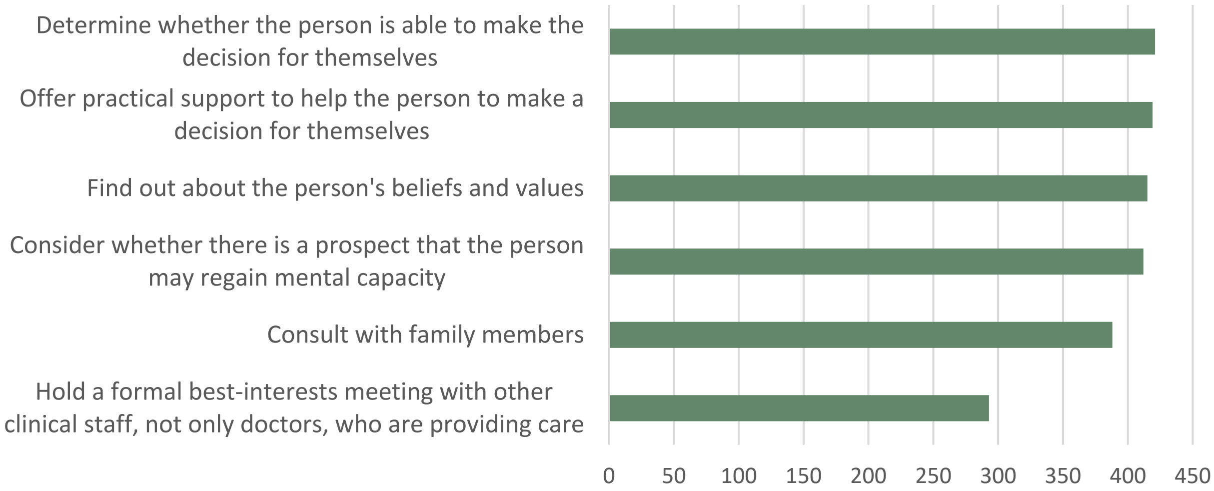
(1) Confidence in applying the MCA;
(2) Steps in best-interests decision-making;
(3) Best interests as a medical question,
(4) Best interests as a subjective question;
(5) The most difficult aspects of best-interests assessments.

---

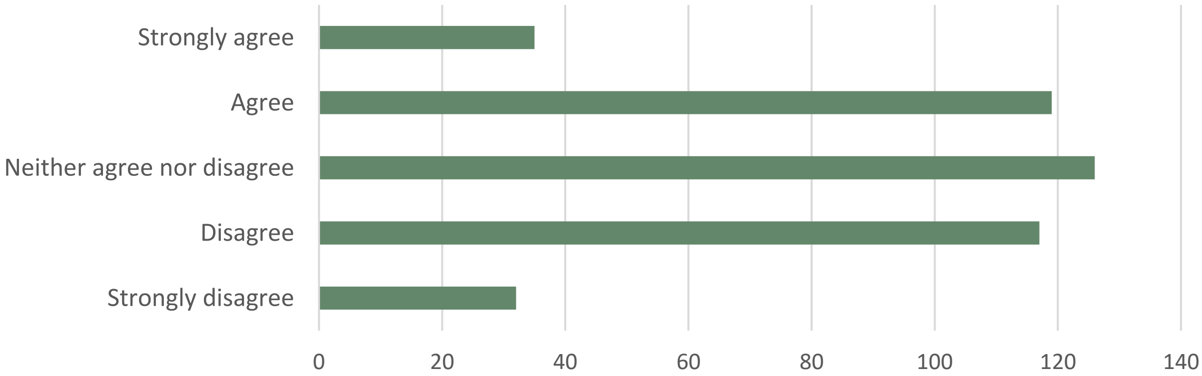
[20] **Note:** this document summarises the answers of the first 500+ registrants, and includes people recruited via GP networks and through the NMCF network.



How confident are you about applying the Mental Capacity Act in making best-interests decisions?

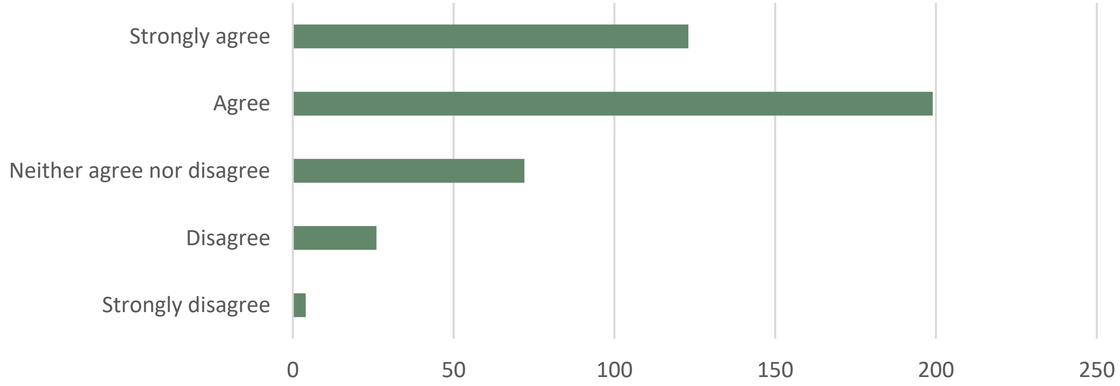


What steps must always be taken before making a best interests decision? (Choose all that apply)



Do you agree or disagree? The question of what medical treatment is in a patient's best interests is ultimately a medical question.

Do you agree or disagree? The question of what is in a patient's best interests is ultimately a subjective question; it is a matter of what the patient would have done in the circumstances if they had been able to make their own decision.



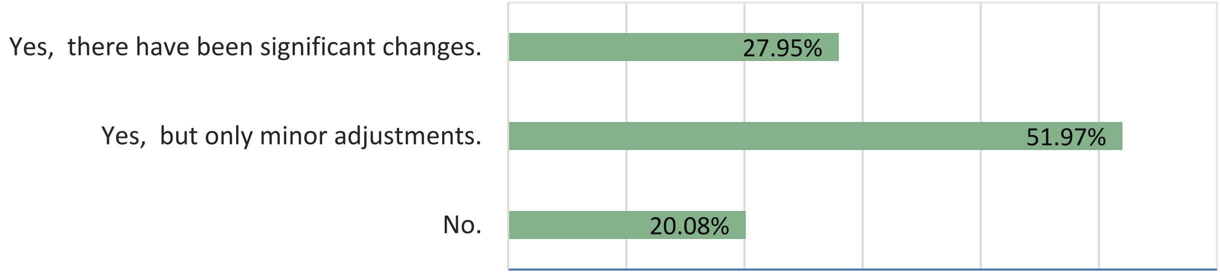
Which aspects of making best interests decisions during the pandemic do you find most difficult?

Webinar 8 – March 22nd, 2021

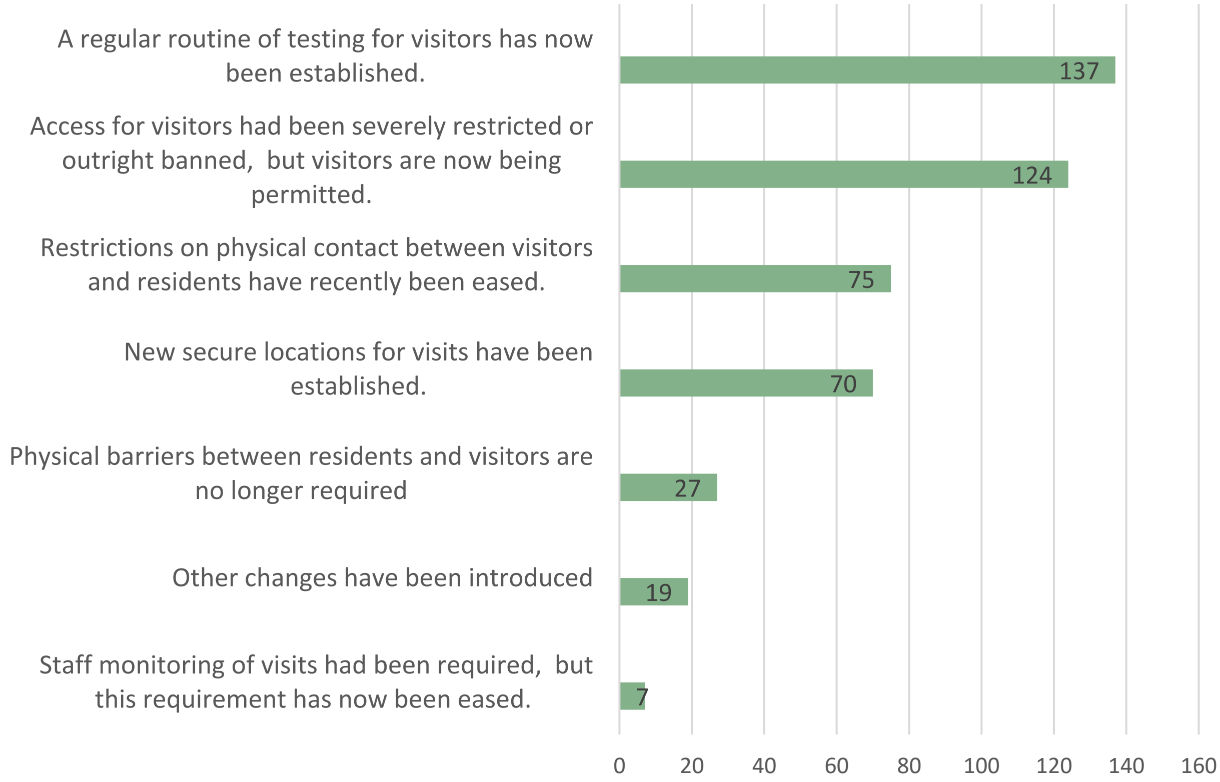
The Good, the Bad, and the Ugly

Participants were asked questions regarding visiting restrictions in care homes and the transition from childhood into adulthood for persons with impaired decision-making capacity.

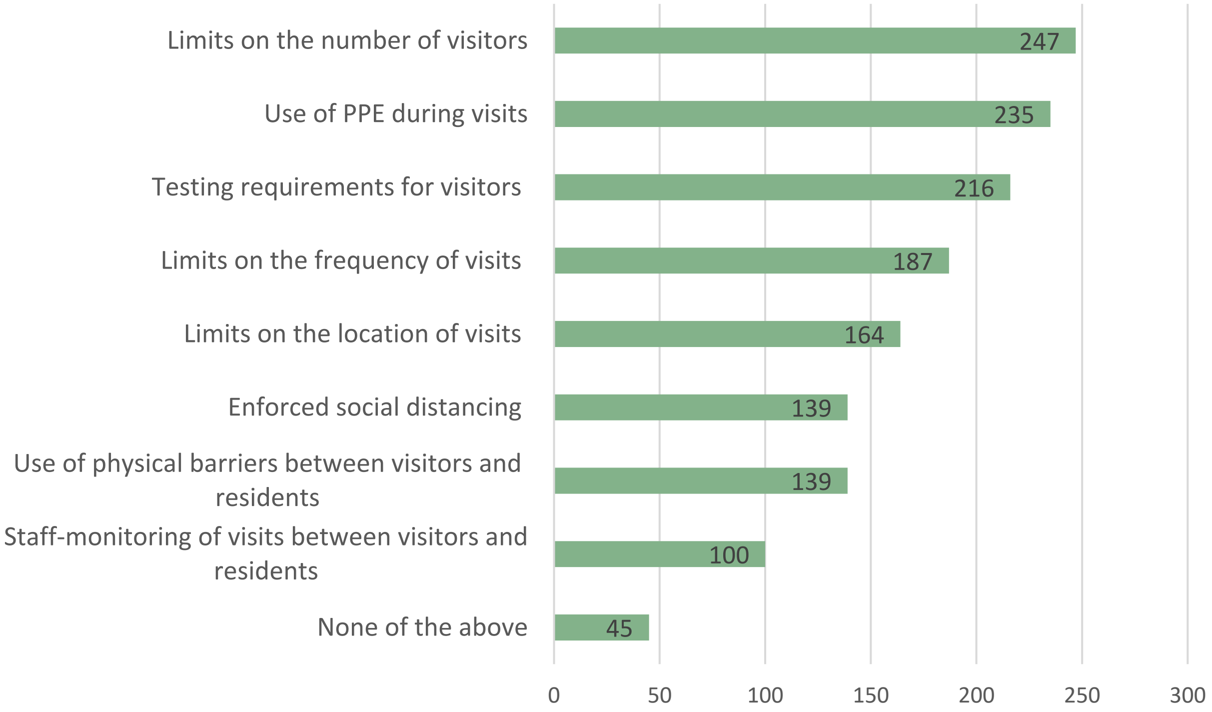
If you have been working in or with care home staff or residents during the pandemic, are you aware of an easing on visitor restrictions in recent weeks?



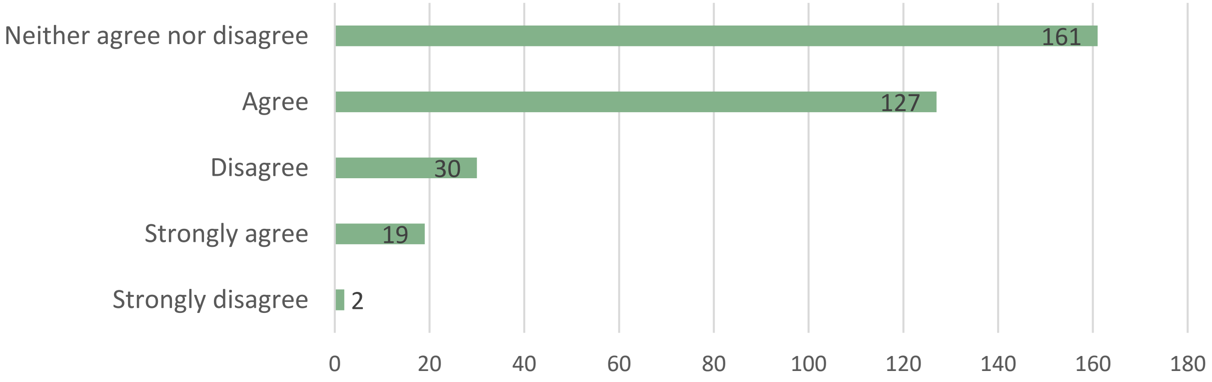
Please indicate what kind of changes you have noticed in recent weeks. (Select all that apply.)



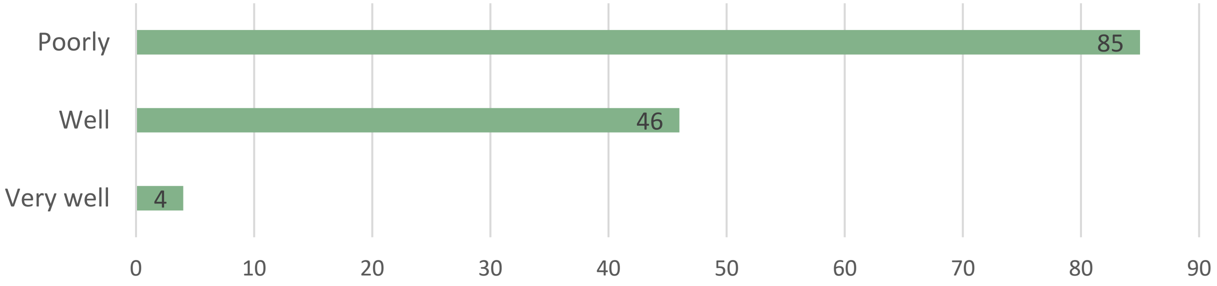
If you indicated that other changes have been introduced, please provide a summary of those other changes here.



Agree or disagree: The care homes with which I am in contact are striking the right balance between risk management and liberty in their current arrangements for visitors.

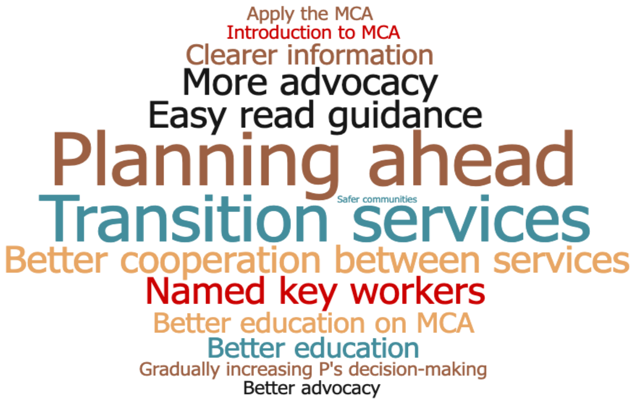


How well do you think that current policies and practices are preparing those clients and their families for navigating that transition?

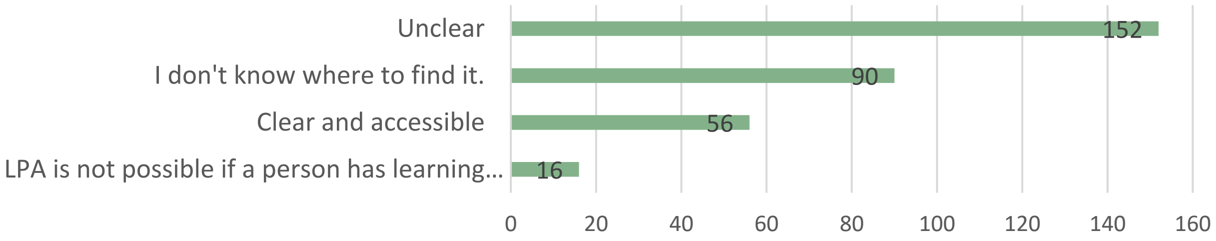


What do you see as the biggest challenge facing persons with impaired decision-making abilities who are navigating the transition between childhood and adulthood?

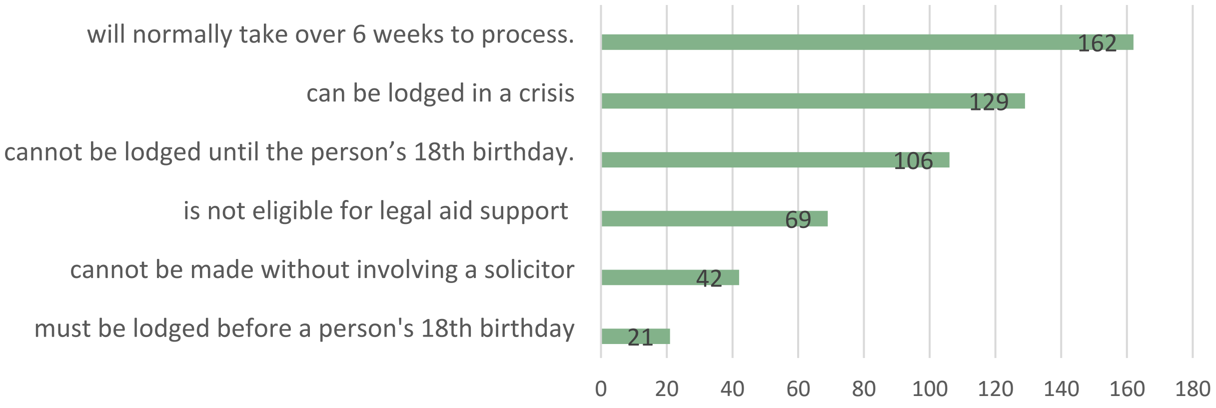
Give an example of a change that could be introduced to help persons with impaired decision-making abilities better navigate the transition between childhood and adulthood?



For people with learning difficulties aged 15-18 the guidance on appointing a person with lasting power of attorney is:



Application to the Court of Protection for deputyship (select all that apply):



Appendix prepared by Dr Emily Fitton, Dr Margot Kulyen and Professor Wayne Martin at the Essex Autonomy Project, University of Essex. https://autonomy.essex.ac.uk/covid-19/
autonomy@essex.ac.uk