## 

## D04

## Autonomy and independence policy (including Mental Capacity Act)

This document is provided to Carers Trust Crossroads West Wales (now referred to as ‘the organisation’) as a Network Partner of Carers Trust.

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# 1.0 SCOPE

1.1 This policy sets out how the organisation will promote the autonomy and independence of people of all ages with care and support needs who use its services. Its intended outcome is to empower and enable them to maximise control over how they live their lives and to support them where possible to make their own choices and decisions.

1.2 This will remain a priority when individuals are transitioning from children’s to adults’ services to ensure that:

* person-centred care and support are at the forefront of any transition
* optimum care and support are provided in accordance with government policy.[[1]](#footnote-1)

1.3 This document will be read in conjunction with the following policy documents:

* equality and diversity (organisation’s own)
* confidentiality and disclosure (D11)
* data protection and subject access (A03)
* positive behaviour (D03).

1.4 In this policy:

* the term ‘staff’ includes employees and volunteers[[2]](#footnote-2)
* the term ‘care planner / assessor’ refers to an employee who is trained and competent in care planning and risk assessment
* the term ‘care worker’ refers to an employee who provides care and support services to people with care needs
* the term ‘service user’ includes parents, carers and people of all ages with care and support needs.

# 2.0 POLICY STATEMENT

2.1 This organisation acknowledges that everyone receiving care and support has the right to freedom and choice over how they live their lives, to be treated fairly, with respect, as an equal and without discrimination.

2.2 We will seek, as far as is reasonably practicable, to comply with the principles and values of co-production[[3]](#footnote-3), working in partnership with people in receipt of services to promote, maintain and maximise their autonomy and independence wherever possible.

# 3.0 TRUSTEE RESPONSIBILITIES

3.1 The organisation’s trustees are personally responsible for ensuring managers have effective systems in place whereby staff comply with this policy at all times when planning and providing services.

# 4.0 RESPONSIBILITIES OF MANAGERS

4.1 Managers will have robust, effective systems in place that ensure staff comply with the autonomy and independence policy when planning or providing services.

4.2 Managers are responsible for ensuring that the principles of this policy underpin the services offered by their organisation, so that those receiving care and support maintain their autonomy and independence for as long as possible.

4.3 Managers will ensure that staff whose role brings them into contact with people who have care and support needs:

* understand the concepts of respect, independence, autonomy, dignity, privacy, confidentiality, and know how to apply them in their work
* are aware of the need to actively listen to and work in partnership with those they care for and / or those acting on their behalf in the decision-making process
* have received training in the Mental Capacity Act (Appendix 1) and consent (Appendices 2 and 3) and understand how these impact on services provided.

# 5.0 RESPONSIBILITIES OF STAFF INVOLVED IN CARE AND SUPPORT

5.1 Staff will be trained and are required to:

* recognise and respect the human rights[[4]](#footnote-4), diversity and values of those with care and support needs, including when those values are different from their own
* respect each person’s right to privacy, dignity and independence
* provide person-centred care and support (see personal care guidance B01c, C02c)
* ensure personal care and support needs are met in an environment that provides as much privacy as possible for the individual concerned
* enable and encourage those with care and support needs to carry out tasks / activities for themselves where possible, rather than increasing dependence by automatically taking over and doing things for them
* be familiar with and apply the principles of the Mental Capacity Act, including how to make day-to-day best interest decisions (Appendix 4)
* inform their manager if they have concerns regarding a person’s mental capacity.

# COMMUNICATION, DECISION-MAKING AND CONSENT

6.1 Communication is a two-way process, involving both the giving and receiving of information. Staff will:

* communicate information to people with care and support needs in ways that maximise their understanding and, where possible, in their preferred language
* support them to express their views to the best of their ability, maximising their participation in any decision-making / consent discussions that affect them.
  1. Staff will enable those with care and support needs to exercise as much choice as possible regarding the care and support they receive, by adopting a decision-making process that is personal to them, supporting them to choose for themselves whenever they can. This principle applies to people of all ages and includes those with a disability or condition that may affect their mental capacity (for example, dementia, autism, brain injury, learning disability) and those who are unable / struggle to communicate, or who communicate differently. See ‘Accessible information guidelines’ (DT12).
  2. Details of each person’s preferred / most effective means of communication will be documented in their care and support / personal plan.
  3. If the person with care needs has mental capacity / competency and chooses to involve relevant others (for example parents, carers, family, friends) in discussions about the services they receive, staff will consult with those people as directed and take their views into account but cannot go against the wishes of the person receiving care and support regarding any decisions they then make.

6.5 For people with care and support needs aged 16 or over who lack the mental capacity to make a particular decision for themselves at the time it needs to be made, the principles of the Mental Capacity Act apply, and decisions taken on their behalf will be made in their best interests.

6.6 If a person aged under 16 is not competent to take a particular decision, their parent / person with parental responsibility[[5]](#footnote-5) can make that decision for them, although the child / young person should still be involved as much as possible in the decision-making process.

* 1. See Appendices 2 and 3 for further details regarding the consent process.

# 7.0 RISK MANAGEMENT

7.1 The organisation recognises that risk taking is an important part of a normal lifestyle for adults and children alike and that individuals have the right to take risks that they understand. We therefore seek to be a risk-aware rather than risk-averse organisation.

7.2 Responsible risk management is about understanding a person’s strengths and capabilities and exploring creative ways for them to be able to do things they want to do, rather than simply ruling them out. Taking a particular risk may be in the best interests of a child, young person or adult with care and support needs within a risk assessment framework that balances the necessary levels of protection and safety with the person’s right to reasonable levels of choice and control.

7.3 Care planners / assessors will:

* take a person-centred approach to identifying, assessing and managing risk, working in partnership with the person concerned and with their carers, family advocates and relevant others as appropriate
* carry out a suitable risk assessment (for example, BT02, CT02) in consultation with the person and / or their parent / carer as appropriate
* provide them with accurate information in a way they can understand
* present and discuss options and choices in a balanced, non-leading way, including associated risks and benefits
* ensure, so far as is reasonably practicable, that staff, those with care needs and the organisation are not exposed to unnecessary, unjustifiable risks
* enable the person to have as much freedom of choice as possible, so long as it does not expose them, or others, to unacceptable risk, taking into account any

learning disability, developmental stage, communication requirements, physical or mental health issues

* decline to carry out any activity / task where the risk cannot be reduced to an acceptable level, fully explaining the reasons for the decision to the person with care and support needs and / or their parent / carer as appropriate
* maintain written records of discussions held, including issues and solutions considered, the views of all parties involved, decisions reached, reasons for these decisions and any unresolved differences.

# 8.0 INFORMATION, FEEDBACK, ADVOCACY AND SIGNPOSTING

8.1 An individual’s feelings of autonomy and independence are enhanced by allowing them as much control over their lives as is reasonably practicable. Staff will strive to keep those with care and support needs and their parents / carers, as appropriate, fully informed about the services they receive by providing them with accurate, up-to-date information at the beginning of, and throughout, their contact with them.

8.2 Service users will be provided at the outset of service provision with a copy of the organisation’s compliments and complaints policy and given details of how to use it (see model compliments and complaints leaflets AT03). All feedback is welcomed and used where applicable to inform future services and ensure continuous improvement.

8.3 Managers will ensure service users are given information about independent advocates and self-advocacy services available in their locality. Both carers and those with care and support needs are eligible for advocacy services (Appendix 7).

8.4 If managers are asked by service users for information about services outside their organisation’s area of activity, they will, where possible, direct them to an appropriate local agency or independent source of information.

# 9.0 LEARNING AND DEVELOPMENT

9.1 For employees involved in the provision of care and support services, general learning and development requirements relating to this policy are contained in the learning and development policy documents (E13).

9.2 Managers are responsible for assessing the roles undertaken by volunteers in their organisation and the level of briefing / induction they require in relation to this policy.

9.3 Training in autonomy and independence will cover practical application of the Mental Capacity Act (to include the topics addressed in Appendices 1 – 7) to a level appropriate to each staff member’s role and responsibilities within the organisation.

**9.4 Care planners / assessors**

Care planners / assessors involved in drawing up / reviewing care and support plans will receive training from an accredited provider (visit [Mental Capacity Act (MCA) training courses | SCIE](https://www.scie.org.uk/training/mentalcapacityact)) Training will include an assessment of competence and be updated / refreshed at least every three years, as appropriate to the level of responsibility of tasks being undertaken.

# 10.0 ADOPTION BY BOARD OF TRUSTEES

10.1 To formally adopt this policy, the organisation’s board of trustees will document in the minutes of the appropriate board meeting its name and reference number and the date it was adopted. The minutes will be signed by the chair of the trustees on behalf of the board.

# 11.0 ACCEPTANCE BY MANAGERS

11.0 Managers and other employees involved in implementing this policy will evidence that they have received, read and understood its contents. Evidence will include:

* document title and reference number
* name and signature of staff member
* job title
* date
* means of indicating ‘received / read / understood’ or otherwise.

11.2 If they indicate they have not understood or have questions about its content, they will be given opportunity to discuss their concerns and provided with additional training as necessary.

11.3 It is then their responsibility to follow the policy. Failure to do so may result in disciplinary proceedings.

# 12.0 ACCEPTANCE BY EMPLOYEES

12.1 Employees are required to sign to indicate that they have received, read and understood the content of this policy as directed by their line manager. If a staff member indicates they have not understood or have questions about its content, they will be given opportunity to discuss their concerns and provided with additional training as necessary. On completion of training, it is then their responsibility to follow it. Failure to do so may result in disciplinary proceedings.

# 13.0 ACCEPTANCE BY VOLUNTEERS

13.1 Volunteers are required to sign to indicate that they have received, read and understood the content of this policy as directed by their co-ordinator. If a volunteer indicates they have not understood or have questions about its content, they will be given opportunity to discuss their concerns and provided with additional information / instruction as necessary. On completion, it is then their personal responsibility to follow it.

# APPENDIX 1

# MENTAL CAPACITY ACT 2005 (amended 2019)

The Mental Capacity Act (MCA) sets out a legal framework of how to act and make decisions on behalf of people aged 16 or over who lack capacity to make a particular decision for themselves. The emphasis of the Act is on empowerment and enablement.

Having a clear understanding of the MCA and how to apply it is critical to the provision of good quality, safe care and support.

The five statutory principles underpinning the Act are:

**1. A presumption of capacity**

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

**2. Individuals supported to make their own decisions**

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

**3. Acceptance that some decisions are ‘unwise’ but still valid**

A person is not to be treated as unable to make a decision merely because they make an apparently unwise decision.

**4. Act in the best interests of the individual**

An act done, or decision made for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

**5. Choose the ‘least restrictive’ option**

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

It is only where a person is deemed to lack capacity to make their own decision/s that the MCA lets other people act without that person’s permission.

Within the Act the term ‘a person who lacks capacity’ refers to a person who lacks the capacity (ability) to make a particular decision or to take a particular action for themselves at the time the decision or action needs to be taken. A person’s ability to make decisions may vary at different times. Some people may have the capacity to make day-to-day decisions but not be able to make more complex ones (see table in Appendix 2 for examples).

A person is deemed to lack capacity if they cannot either:

* understand the information given to them OR
* retain that information long enough to be able to make a decision OR
* weigh up information available and understand the consequences of a decision OR
* communicate their decision (for example verbally, by using sign language, simple muscle movements such as blinking an eye or squeezing a hand, or by other means).

Every effort should be made to find ways of communicating with someone before deciding they lack capacity to make a decision based solely on their inability to communicate. Staff need to take all practical, appropriate steps to enable and support that person to make the decision for themselves, in a way that reflects their individual circumstances and meets their needs, such as:

* providing them with all relevant information, including, if there are choices, details of the alternatives
* communicating information in the easiest and most appropriate form for the person concerned to understand, which may for example include use of pictures cards, photographs, videos, sign language
* involving someone who knows the person well (such as a relative, friend, advocate) to help them understand
* making the person feel at ease, allowing sufficient time for them to consider the information they have been given
* supporting the person to communicate their decision.

For more information see [Mental Capacity Act Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)

# APPENDIX 2

# CONSENT - ADULTS

When setting up a new care and support service for people aged 18 or over, or when proposing changes to existing services, the care planner / assessor is required to obtain the appropriate consent.

Consent will be treated as a process that continues throughout the duration of the service; it can be withheld or withdrawn at any time.

The person with care needs will be given information in a format they can understand and that meets their communication needs prior to being asked to consent to proposed care and support services (see Appendix 1 above).

1. **PERSON HAS MENTAL CAPACITY TO CONSENT TO CARE AND SUPPORT**

A person with care needs who has mental capacity will be asked to indicate their informed consent[[6]](#footnote-6) to proposed services.

Ways of indicating that the person understands and agrees with the content of a proposed care and support / personal plan could include:

* their signature (in paper or electronic format)
* witnessed verbal consent
* use of sign language
* clear, active assent (such as nodding the head, blinking an eye, squeezing a hand).

The care planner/ assessor will fully document the consent process followed and the person’s means of indicating their agreement.

1. **PERSON LACKS MENTAL CAPACITY TO CONSENT TO CARE AND SUPPORT**

If the care planner / assessor has been informed by a healthcare professional or has reasonable belief that a person with care needs lacks capacity to consent to proposed services, they will first determine whether the services being proposed involve day to day, non-complex decisions about routine care and support or involve decisions of a more complex nature. See table below for examples.

|  |  |
| --- | --- |
| **Day-to-day, non-complex decisions** | **Complex decisions** |
| Taking part in education, leisure and social activities | Disagreements regarding a person’s capacity to make decisions |
| Mobility requirements | Change of accommodation |
| Eating and drinking | Life-saving or significant treatments |
| Personal hygiene, washing, dressing | Use of covert medication |
| Shopping | Use of restrictive intervention (see D03) |
| Tasks around the home | Significant financial or property issues |

Day-to-day, non-complex care and support planning

If proposed services consist of straightforward, routine, non-complex care and support, the care planner / assessor may carry out a basic mental capacity assessment if they deem it to be appropriate, within their skill set and in line with the training they have received (see 9.4 in main text of policy above), seeking expert advice where necessary (for example, from relevant healthcare professionals such as doctor, social worker).

While carrying out the planning and consent process involving routine, non-complex care and support for a person deemed to lack capacity, the care planner / assessor will remain proactive in encouraging and supporting them to make whatever decisions they can for themselves in line with the principles of the MCA as set out in Appendix 1.

The care panner / assessor will ensure that, where the person with care needs is unable to make a decision for themselves regarding care planning and consent, all such decisions are taken in the person’s best interests, working in partnership with relevant others as appropriate (for example, their carer, person/s with lasting power of attorney, social worker, general practitioner, pharmacist).

The care planner/ assessor will fully document the assessment, decision-making, planning and consent process followed as appropriate, including who was involved and how best interest decisions were reached.

Complex care and support planning

If proposed services for a person who lacks capacity involve complex or major decisions that may have significant, far-reaching consequences (see table above), or if the care planner / assessor has concerns about the complexity of decisions needing to be addressed, this is deemed to be outside their level of expertise. In such circumstances, the care planner / assessor will escalate the matter to a relevant healthcare practitioner / other professional / expert, (such as social worker, general practitioner, psychiatrist, psychologist) as appropriate.

The professionals involved may decide to formally assess the person’s mental capacity regarding complex decisions and may hold a multi-disciplinary team meeting to consider the benefits or otherwise of any proposed care and support and whether it is in the person’s best interests to provide it. If the person concerned has made an Advance Decision or there is a Lasting Power of Attorney or Court of Protection Deputyship Order in place, this will inform any best interest decisions taken.

Details of the mental capacity assessment / consent process and outcomes relevant to proposed care and support provision will be recorded in the person’s file as appropriate.

Further information

* [Mental Capacity Act Guidance (Care Quality Commission)](https://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf)
* [Decision-making and mental capacity guidelines](https://www.nice.org.uk/guidance/ng108/chapter/Recommendations) (National Institute for Health and Care Excellence)

# APPENDIX 3

# CONSENT - CHILDREN

When setting up or reviewing the provision of services for a child or young person aged 17 or under, the care planner / assessor must obtain appropriate consent for all care and support provided. A model care and support / personal plan incorporating a suggested consent form is available at CT03.

Consent must be treated as a process that continues throughout the duration of the service; it can be withheld or withdrawn at any time. When discussing consent issues with a child or young person, the care planner / assessor will ensure information is provided in a way they can understand and that meets their communication needs.

If a child or young person is deemed competent to give consent for their own care and support, care planners / assessors will obtain it directly from them (see ways off indicating informed consent as set out in Appendix 2).

The legal position regarding “competence” is different for children aged under 16 and young people aged 16 and 17.

## Children aged under 16

There is no specific legal age when a child becomes competent to consent to treatment or care; it depends both on the child and the seriousness or complexity of the treatment or care being proposed. Children aged under 16 are deemed competent to give valid consent to care if they have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed” (sometimes known as “[Gillick competency](https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf)”).

If a child under 16 is deemed competent to consent for themselves, it is still good practice to involve their parent / person with parental responsibility in decision-making, unless the child specifically states otherwise.

If a child under 16 is deemed not competent to make a particular decision, their parent / person with parental responsibility can take that decision for them (acting in the child or young person’s best interests) although the child should still be involved as much as possible.

## Young people aged 16 and 17

Once children reach the age of 16, they are presumed in law to be competent to give consent for themselves and the Mental Capacity Act 2005 applies (see Appendix 1). So, for example, if a signature is required on a consent form, they can sign for themselves if able to do so. However, it is good practice to involve their parent / person with parental responsibility in decision-making unless the child or young person states otherwise.

## Best interests

A decision taken on behalf of a child or young person who is not competent or able to make it themselves, must be taken in the child or young person’s best interests, in consultation with their parent / person with parental responsibility.

In some cases, a multi-disciplinary ‘best interests’ meeting may be held, comprising professionals involved in the care of the child or young person, their parent / person with parental responsibility, carer, close family members as appropriate.

* The benefits or otherwise of proposed care will be discussed and a decision made about whether it is in the child or young person’s best interests.
* The outcome of the meeting will be recorded in the child or young person’s file and all necessary information regarding service provision entered in their care and support / personal plan.

# APPENDIX 4

# BEST INTERESTS DECISIONS

The MCA states that any act done for, or any decision made on behalf of a person who lacks capacity must be done or made in that person’s best interests.

**Common factors when making best interests decisions**

* Working out what is in someone’s best interests cannot be based simply on their age,

appearance, condition or behaviour.

* All relevant circumstances should be considered.
* Every effort should be made to encourage, support and enable the person who lacks capacity to take part in the decision-making process.
* If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent.
* Special considerations apply to decisions about life-sustaining treatment[[7]](#footnote-7).
* The person’s past and present wishes, feelings, culture, background, beliefs, values

and preferences should be taken into account.

* The views of other people close to the person who lacks capacity should be considered, as well as those of any appointed representatives or advocates.

**Care and support / personal plan**

Each person’s care and support / personal plan will document:

* details of the care and support to be provided
* the extent to which the person is able to make decisions for themselves
* those tasks / actions the person is normally able to decide about / consent to themselves
* those tasks / actions the person will not normally be able to decide about or consent to
* details of the level and type of support needed to help a person make their own decisions or to participate in the decision-making process
* how decisions are made in their best interests.

**Day-to-day decisions (see table in Appendix 2 for examples)**

Staff will be trained to support individuals to make their own day-to-day decisions as far as possible in relation to these tasks and activities and to encourage them to indicate their wishes by any means appropriate. If they are unable to do so, then all decisions taken on their behalf will be in the person’s best interests as described above.

The Act recognises that routine, day-to-day, best interests decisions, taken for example, by a care worker in the course of providing care and support, do not require a formal, recorded mental capacity assessment each time such a decision is taken. Staff receive protection from liability within the MCA if they have a reasonable belief that the person concerned lacks capacity to make such a decision for themselves at the time it needs to be made.

**Complex decisions (see table in Appendix 2 for examples)**

Complex decisions are subject to a formal assessment process to be carried out by trained professionals (such as medical practitioners, social workers, psychiatrists, psychologists) and are outside the remit of the organisation’s staff.

**Children**

The primary principle of the Children Act is that the child or young person’s interests are of paramount importance in all decisions made about their welfare. When working with children and young people aged 15 and under, staff will apply this principle, working in partnership with the child’s parent / person with parental responsibility to promote the best outcomes for the child or young person concerned.

# APPENDIX 5

# DIGNITY

Respecting a person’s dignity involves recognising their intrinsic value as an individual, their unique qualities and the contributions they make. Having a disability or needing help can easily undermine dignity.

Staff will:

* strive to provide high quality services that promote the dignity of people with care needs
* have a zero tolerance of all forms of abuse
* support people with the same respect they would want for themselves or their family
* treat each child, young person, adult as an individual by offering a personalised service
* enable them to maintain maximum independence, choice and control
* help them to be confident and maintain a positive self-image
* listen to and support them to express their needs and wishes
* respect their right to privacy
* ensure they feel able to complain about services provided without fear of retribution
* engage respectfully with family members and carers as care partners
* act to alleviate the loneliness and isolation that can be experienced by people of all ages with care and support needs, their parents and carers.

# APPENDIX 6

# DEPRIVATION OF LIBERTY SAFEGUARDS and LIBERTY PROTECTION SAFEGUARDS

There is no implementation date available for when the proposed Liberty Protection Safeguards (LPS) will replace the current Deprivation of Liberty Safeguards (DoLS).

**DEPRIVATION of LIBERTY SAFEGUARDS (DoLS)**

DoLS apply to people aged 18 or over who:

* lack capacity
* are being cared for in a hospital or care home setting
* are being deprived of their liberty.

A person who lacks capacity is deemed to be deprived of their liberty if:

* they are subject to continuous supervision and control **AND**
* they are not free to leave.

DoLS:

* form part of the Mental Capacity Act
* exist to protect people who lack capacity when depriving them of their liberty is an unavoidable part of a best interests care and support / personal plan
* **do** **not** apply directly to people receiving care and support in their own home.

If a person is suspected of being deprived of their liberty (as defined above) in their own home, it will be dealt with via the Court of Protection rather than through DoLS. In such circumstances managers are advised to seek advice from the appropriate commissioner or local authority.

**Underpinning principles of DoLS**

It is recommended that staff who provide care and support to people in their own homes are aware of the principles that underpin DoLS. These are as follows.

1. A person may only be deprived of their liberty when:

* it is in their best interests to do so
* there is no other way to keep the person safe or to provide them with the care and treatment they need.

2. Care and support must be provided in the least restrictive way possible.

3. A person’s freedom must not be inappropriately restricted when providing care and support.

**LIBERTY PROTECTION SAFEGUARDS (LPS)**

The overall intention of the LPS is to continue to protect people's rights, but in a simpler and less bureaucratic way than DoLS.

LPS put the person at the centre of the decision-making process, seeking to increase their participation, voice and control.

LPS are expected to incorporate the following changes relevant particularly to regulated domiciliary care services.

* They will apply to 16- and 17-year-olds.
* They will extend to include domestic settings, applying to people living in their own homes as well as those who are in hospitals and care homes, removing involvement of the Court of Protection in the process.

For further information, visit: [What are Liberty Protection Safeguards? | SCIE](https://www.scie.org.uk/mca/lps/latest) o

# APPENDIX 7

## ADVOCACY

**Advocacy:**

* is taking action to help people say what they want, secure their rights, represent their interests and obtain the service they need
* promotes social inclusion, equality and social justice
* seeks to give the person concerned as much control as possible over their life.

**Different types of advocacy**

1. Self-advocacy, where the person concerned is able to speak up for themselves and express their views, wishes and feelings.
2. Informal advocacy, where for example a family member, informal carer or friend speaks up on a person’s behalf when they are unable or unwilling to do so for themselves.
3. Professional advocacy, where a trained professional (for example, solicitor, social worker) actively supports and represents a person who is unable to do so themselves and has no-one else to do it for them. Many voluntary organisations provide professional advocacy services, for example, MIND, Age UK, Voice for the Child in Care.

**Advocates:**

* speak up for or represent the best interests of people who are unable or unwilling to represent themselves in matters relating to their personal care and support
* work in partnership with the people they support and take their side
* empower the person concerned by enabling them to express their own needs, helping them to understand information, communicate what they want and need
* offer support during such processes as assessment, care planning, reviews
* help the person to provide feedback, express concerns or make a complaint.

Managers are required to inform service users of their right to advocacy and provide them with information of local independent advocacy schemes available to them.

For further information, see:

* England: [Independent advocacy under the Care Act 2014](https://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/duties/independent-advocacy-care-act.asp)
* Wales: [Advocacy and access to information under the Social Services and Well-being Act 2014](https://www.scie-socialcareonline.org.uk/advocacy-and-access-to-information-under-the-social-services-and-well-being-wales-act-2014/r/a110f00000NeCWnAAN)

1. # See [NICE guidelines [NG43]](https://www.nice.org.uk/guidance/ng43) regarding children’s transition to adult services.

   [↑](#footnote-ref-1)
2. The National Council for Voluntary Organisations (NCVO) defines volunteering as ‘any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each individual’. [↑](#footnote-ref-2)
3. Co-production, as set out in the Care Act 2014, seeks to develop more equal partnerships between people

   who use services, carers and professionals to ensure the care and support provided is the best it can be. For

   more information, see Social Care Institute for Excellence guide ‘[Co-production: what it is and how we do it](https://www.scie.org.uk/co-production/what-how) [↑](#footnote-ref-3)
4. [The Human Rights Act (HRA) | Overview for social care | SCIE](https://www.scie.org.uk/key-social-care-legislation/human-rights-act#:~:text=Human%20rights%20underpin%20our%20social,your%20private%20and%20family%20life) [↑](#footnote-ref-4)
5. ‘Parent / person with parental responsibility’ as defined in Section 2 of the Children Act 1989:

   * Having parental responsibility is legally distinct from being recognised as a child’s mother or father.
   * Parental responsibility means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and their property.

   The term ‘parent’ does notinclude professional support staff or carers (unless they are also the parent / person with parental responsibility). [↑](#footnote-ref-5)
6. ‘Informed consent’ means that sufficient evidence-based information has been provided to the person with care needs to enable them to make a balanced and informed decision about their care and treatment (Royal College of Nursing April 2023) [↑](#footnote-ref-6)
7. For further information on life-sustaining treatment, see the adults’ and children’s resuscitation policy documents (B03, C04). [↑](#footnote-ref-7)