South Tees
Clinical Commissioning Group

Mental Capacity Act and Deprivation of Liberty

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Status	Final
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Author	CCG Head of Safeguarding NECS Commissioning Manager, CHC
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Policy Validity Statement
This policy is due for review on the date shown above. The policy will remain valid, but must be reviewed within each 2 year period.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
1	28/02/2013	Senior Governance Manager	Policy provided to Clinical Commissioning Group (CCG) as part of policy suite.
2	November 2016	CCG Head of Quality and Adult Safeguarding	Full Review of Policy.
2.1	November 2018	CCG Head of Quality and Adult Safeguarding	Reviewed. No amendments required. Extension request.

Approval

Role	Name	Date
Approval	Governance & Risk Committee	November 2016 (2)
Approval	Governance & Risk Committee	November 2018 (3)

Review

This document will be reviewed 2 years from its issue date.

Table of Contents

1. Introduction

This policy sets out how as a commissioning organisation NHS South Tees Clinical Commissioning Group (South Tees CCG) will fulfil its duties and responsibilities effectively both within its own organisation and across the local health economy via its commissioning arrangements in relation to the Mental Capacity Act (MCA) 2005. It also includes reference to the Deprivation of Liberty Safeguards (DoLS), as commissioners must understand the implications of DoLS, and South Tees CCG commissioned services must demonstrate as appropriate compliance with DoLS.

For the purposes of this policy, South Tees CCG will be referred to as 'the CCG'.

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The CCG, as a member of the local Safeguarding Adults Board, Local Adult Safeguarding Sub Groups and Local Executive Groups has formally adopted the principles of the Safeguarding Adults Inter-Agency Policy and Procedures which references the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

This policy should be read in conjunction with the

- The Mental Capacity Act: Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- Deprivation of Liberty Safeguards (DoLS): Code of Practice
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Important to Note The Law Commission have carried out a four month consultation (August – November 2015) and are currently reviewing the policy on Deprivation of Liberty Safeguards and propose changing current legislation to a new 'Protective Care Scheme' the aim is to help clarify and simplify what is currently in some cases a complex process and to have a separate process for each setting. It is anticipated this new law will gain royal ascent until November 2017 at the earliest and at least 2020 before any changes to process occurs. This policy will need to be reviewed and amended at that juncture,

1.1. Status

This policy is a corporate policy.

1.2. Purpose and Scope

The purpose of this policy is to support the CCG in discharging its duties and responsibilities as a commissioner. This requires the CCG to understand and be able to apply the principles of the Mental Capacity Act (MCA) 2005 Code of Practice, and Deprivation of Liberty Safeguards (DoLS) Code of Practice, so they can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests. Commissioned services are expected to demonstrate compliance with both Codes of practice and any legal changes as a result of case law.

This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff.

All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

2. Definitions

2.1. The following terms and abbreviations are used within this document:

Reference	Abbreviated Term
Mental Capacity Act	MCA
Mental Health Act	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	COP
Lasting Power of Attorney	LPA
Enduring Power of Attorney	EPA
Advance Decision to refuse treatment	ADRT
General Practitioner	GP
Deprivation of Liberty Safeguard	DoLs
Supervisory Body	SB
Managing Authority	MA

2.2. Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain.

An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- A substance misuse

Lacking capacity is about a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

Lack of Capacity must be established following the processes outlined in Appendix A, and B.

2.3. Equality and Diversity Lead

The Chief Finance Officer is the Equality and Diversity Lead for the CCG.

3. Mental Capacity Act Principles

3.1. The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- You have observed the principles of the MCA
- You have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in questions
- You reasonably believe the action you have taken is in the best interests of the person

3.2. Provided you have complied with the MCA in assessing capacity and acting in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA))
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay.
- Placements in residential care

3.3. There are five key principles underpinning the MCA as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not unable to make a decision unless all steps have been taken unsuccessfully.
3. A person is not unable to make a decision merely because he makes an unwise decision.
4. An act/decision made behalf of a person who lacks capacity must be in his best interests.
5. Before the act or decision, ensure it is achieved in the least restrictive way.

3.4. The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, **a person must be aged 18 or over.**

The Act also introduces a number of bodies and regulations that staff must be aware of (see appendix 2)

4. Deprivation of Liberty Safeguards (DoLS)

NOTE: Significant Changes

- The CCG no longer have responsibility as the Supervisory body, this lies solely with the local authority.
- Any death under DOLS authorization MUST be reported to the cornoner before a death certificate can be written in line with the Coroners and Justice Act 2009.
- Http://www.legislation.gov.uk/ukpga/2009/section/1
- Criteria for eligibility for a DoLS assessment has significantly changed and widened the scope of the Act to include a lot more people.

4.1. Whilst a Deprivation of Liberty (DoL) may occur in any care setting, the DoL safeguards provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements. Those affected by the DoL safeguards will include people with a "mental disorder", as defined within the Mental Health Act (1983) (2007), who lack the capacity to make informed decisions about arrangements for their care or treatment. The DoL safeguards clarify that a person may be deprived of their liberty:

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- it is in their own best interests to protect them from harm, and;
- if it is a proportionate response to the likelihood and seriousness of the harm, and;
- it is the least restrictive way of meeting their needs safely.

On 1st April 2013, Primary Care Trusts ceased to exist and their Supervisory Body (SB) role was transferred to Local Authorities (LA). As such the CCG's are not Supervisory Bodies (SBs) but they are required to work closely with providers and the LA's to ensure the protections offered by the safeguards are implemented appropriately.

On 19th March 2014, the Supreme Court published its' judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases. This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an 'Acid Test'. For a person to be deprived of their liberty, they must :
lack the mental capacity to consent to the relevant care and support arrangements, where they have been put in place by the State.

And be:

- subject both to continuous supervision and control
- **And** not be free to leave.

In all cases the following are NOT relevant to the application of the test:

1. The person's compliance or lack of objection to the care arrangements.

2. The reason or purpose behind a particular placement; and

3. The relative normality of the placement (whatever the comparison made). This means that the person should not be compared with anyone else in determining whether there is a Deprivation of Liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities).

In introducing the 'Acid Test', it has reduced the threshold and widened the scope of whom may be affected, to cover Independent Living Schemes, Adult Placements, Children's Foster Placements and potentially even people at home receiving Continuing Health Care (CHC) funded packages of care.

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorised obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), The Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (COP). The CCG should be able to seek assurance from its commissioned services that they are compliant with the DoLS framework and COP requirements. This includes the Commissioning Support Service (CSU) who provide Continuing Health Care Services (CHC), as well as providers of NHS funded care.

Any unauthorised Deprivations will carry with it a potential risk of litigation. If the CCG identifies via its commissioned services such a risk exists, this should be included on the risk register and an action plan to address the risk developed and reviewed in accordance with the CCG Risk management arrangements.

5. Governance and Accountability

5.1. The CCG Governing Body is responsible for making certain all its provider services have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. The governing body through its governance structures namely the Quality Performance and Finance Committee (QPF) will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DOLs.

5.2. The CCG will ensure effective leadership, commissioning and governance through the following:

- Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and that South Tees CCG commissioning, contracting, contract monitoring and quality assurance processes fully reflects this: MCA and DoLS is an agenda item on the provider services' Clinical Quality Review Groups (CQRGs) in accordance with the CQRG Forward Plan.

- Ensuring service specifications, invitations to tender and service contracts fully reflect MCA and MCA DoLS requirements as outlined in this policy with specific reference to the clear standards for service delivery.

- Ensuring a system is in place for escalating risks.

6. Service Contract Standards

6.1. Clear service standards for ensuring compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) will be included in NHS commissioned services contracts, as appropriate to the service.

6.2. The CCG will seek assurance from providers in relation to these standards via its contract management and quality assurance processes.

7. Duties and Responsibilities

7.1. Governing Body (GB)

The CCG has delegated responsibility to the Governing Body for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.

7.2. The Chief Officer

The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.

The Chief Officer is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements.

This role is supported by the Executive Nurse who holds delegated responsibility and is the executive lead for Safeguarding Adults. The Head of Quality and Safeguarding provides expert advice to the Governing Body on MCA and MCA DoLS matters.

7.3. The Executive Lead for safeguarding adults

The CCG Executive Nurse, as executive lead for safeguarding adults, MCA and MCA DoLS, will ensure South Tees CCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a programme of training and mentoring to support the Head of Quality and Safeguarding for MCA, MCA DoLS. The Executive Nurse is the Sponsoring Director for this policy and is responsible for ensuring that:

- This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
- The necessary training required to implement this document is identified and resourced.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.
- The CCG has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers

7.4. Designated Professional (Adult Safeguarding and MCA, MCA DOLS Lead)

The Head of Quality and Safeguarding as the designated professional and MCA and MCA DoLS lead will take a strategic and professional lead on all aspects of the NHS contribution to MCA and MCA DoLS across the CCG's area, which includes all commissioned providers. They will:

- Work with the Executive Nurse to ensure robust assurance arrangements are in place within the CCGs and provider services.
- Provide advice and expertise to the CCG's governing bodies and to the Teeswide Safeguarding Adults Board and associated groups and to professionals across both the NHS and partner agencies.
- Provide professional leadership, advice and support to lead adult safeguarding professionals across provider trusts/services and independent contractors.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS.
- Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.
- Provide advice and guidance in relation to MCA, MCA DoLS training including standards.
- Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and compliance is evidenced.
- The Head of Quality and Safeguarding will work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's safeguarding teams.

7.5. Managers and Executive Leads

Managers and Executive leads have responsibility for:

- Ensuring they are aware of and carry their responsibilities in relation to MCA, MCA DoLS.

- Ensure that the MCA and DoLS policy is implemented in their area of practice.

- Ensuring staff are aware of the contact details of the CCG Head of Quality and Safeguarding, and CSU Adult Safeguarding Team and the local authority contact number for safeguarding concerns.

- Ensuring that all CCG staff undertakes mandatory MCA, and MCA DoLS training commensurate to their role.

7.6. CCG Staff

All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:

- Comply with the MCA and DoLS Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.
- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager
- Complete mandatory MCA and MCA DoLS training in accordance with the CCG Safeguarding Adult and MCA, MCA DoLS Training Plan.
- Where the CCG employee in performing their duties feels a deprivation of Liberty is taking place but the managing authority (hospital/care home/hospice/supported living setting/domestic setting)are **not** acting on concerns that a person meets the eligibility criteria for DoLS authorisation they should contact the responsible Local Authority Supervisory Body to make a third party application.

7.7. Commissioning Support Unit (CSU)

The CCG commission adult safeguarding support services, Continuing Health Care Services (CHC) and Medicines Optimisation Services from the Commissioning Support Unit. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSU will be expected to comply with the Service contract standards relating to MCA. MCA DoLS.

8. Implementation

8.1. This policy will be available to all Staff within the CCG via the shared intranet and the internet sites.

8.2. All Executive leads and Managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties.

8.3. The CCG Executive Nurse, as executive lead for safeguarding adults MCA and MCA DoLS, will ensure the CCG has effective professional appointments, systems, processes and structures in place to support the Designated Nurse Safeguarding Adults for MCA, (MCA) DoLS. The Executive Nurse is the Sponsoring Director for this policy and is responsible for ensuring that:

- This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
- The necessary training required to implement this document is identified and resourced.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Chief Officer and governing body members are made awareof any concerns relating to a commissioned service.

- The CCG has in place assurance processes to ensure compliance with MCA,MCA DoLS legislation, guidance, policy, procedures code of practice, quality standards, and contract monitoring of providers.

9. Training Implications

9.1. The training required for CCG staff to comply with this policy are:

- Mandatory Safeguarding Adults , MCA, including MCA DoLS training programme
- Bespoke training provided by the CCG Head of Quality and Safeguarding

10. Documentation

10.1. Other related policy documents

- Guidance on Advance Decision to Refuse Treatment (ADRT)
- Safeguarding Adults Policy

10.2. Legislation and statutory requirements

- Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.
- Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- Cabinet Office (1983) *Mental Health Act 1983*. London. HMSO
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO
- Department of Health (2007) *Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.* London. DH.
- Department of Health (2009) *The Mental Capacity Act Deprivation of Liberty Safeguards.* London. DH.
- Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office
- P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190

10.3. Best practice recommendations

- Department of Health. (2006) *Records Management: NHS Code of Practice.* London: DH.
- Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

11. Monitoring, Review and Archiving

11.1. Monitoring

The CCG governing body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

11.2. Review

The CCG governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

11.3. Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

12. Equality Analysis

A full Equality Impact Assessment has been completed:

EIA - MCA DOLS
(South Tees and HaS

Appendix 1

Procedural Intervention

1. Introduction

1.1 When a person is in your care and needs to make a decision you must assume that person has capacity and make every effort to support and encourage the person to make the decision themselves. Also remember that people can make unwise or eccentric decisions, but this does not mean they lack capacity.

1.2 This could include:

- Does the person have all relevant information?
- Could the information be explain or shown more easily?
- Are there particular times of the day when a person's understanding is better?
- Can anyone else help to support the person?

1.3 Every effort must be made to encourage and support a person to make a decision for themselves. If this is difficult, an Independent Mental Capacity Advocate (IMCA) is a new service offering a specific type of advocate that will only be involved if there is no-one else appropriate and in specific situations such as:

- Decision about serious medical treatment
- Decisions about moving into long term care – 8 weeks +
- The IMCA will obtain and evaluate relevant information
- Discuss the proposed decision with professionals and others concerned
- Find out as far as possible their wishes and feelings
- Consider making alternative courses of action
- Get further medical opinion where necessary
- Provide a report with submissions for the person making the decision

1.4 When there is reason to believe a person does lack capacity at this time consider:

- Has everything been done to help and support the person?
- Does the decision need to be made without delay?
- Is it possible to wait until the person has the capacity to decide?

1.5 If the person's ability to make a decision still seems questionable then you will need to assess capacity.

Two Stage Capacity Test

Stage 1

Does the person have an impairment of, or a disturbance in the functioning of their mind or brain?

Examples may include the following:

- Dementia
- Significant learning disability
- Brain damage
- Delirium
- Concussion
- Symptoms of drug or alcohol use
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness

If no impairment is present then the person cannot lack capacity under the Act.

Stage 2

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

Stage 2 can only apply when all practical and appropriate support to help the person make the decision has failed.

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

1. Understand information about the decision to be made (the Act calls this relevant information).
2. Retain that information in their mind (long enough to make an effective decision)
3. Use or weigh that information as part of the decision making process, or
4. Communicate their decision (by talking, using sign language or any other means)

2. Decision Making

2.1 The person responsible for undertaking the capacity test is the **Decision Maker.** The person who assesses a person's capacity to make a decision will usually be the person who is directly concerned with that person at the time the decision needs to be made. It should be the most appropriate person in relation to the type of decision involved. This means that different people will be involved in assessing a person's capacity at different times and for the CCG they will be a **qualified professional** as follows:

- Qualified Nurses
- Physiotherapists
- Occupational Therapists
- Other Allied Health Professionals
- GPs

2.2 However, if a person has a Lasting Power of Attorney or Court Deputy then that person would act as the decision maker within the remit of their legal powers. For example finance and property or health and welfare or both if stated.

2.3 It is important to consider the following:

- What is the Decision that needs to be made?
- Who will be involved generally?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?

2.4 You should consider the following prompts prior to decision making:

- The environment is appropriate where it is quiet and uninterrupted.
- The person has the relevant information and in a format that they can understand? Do not burden the person with more detail than necessary.
- Could it be explained in an easier way and do you need help from other people for example a Speech and Language Therapist or an Interpreter to help with any issue of communication?
- Is this the right moment or place to discuss this, does the person seem comfortable discussing this issue now?
- Can anyone else assist? Consult with family and other people who know the person well.
- Does the decision have to be made now? Try to choose the best time for the person and ensure that the effects of any medication or treatment are considered.
- Can this wait until the person has capacity if the loss is temporary?
- Be aware of cultural factors, which may have a bearing on the individual. Consider whether an advocate is required.
- Take it easy. Make one decision at a time.

2.5 You must always follow the five key principles of the MCA in any decision-making and assess at a person's best level of functioning for the decision to be taken.

2.6 The MCA states that "assessment of capacity to take day to day decisions or consent to care require no formal assessment procedures". However although day-to-day assessments of capacity may be informal, they should still be written down by staff. Therefore if an employee's decision is challenged, they must be able to describe why they had a reasonable belief of a lack of capacity. Therefore recording should always be inserted within a patient's case notes or care plan.

2.7 In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear and recorded process. In order to achieve this a Record of Capacity Test and Best Interests Assessment form (PCT/MCA 1) must be completed.

3. Functional Capacity Test

3.1 When should capacity be assessed? This must be decision specific which means that:

- The assessment of capacity must be about a particular decision at a particular time – not a range of decisions

- If someone cannot make a complex decision, don't assume they cannot make a simple decision
- You cannot decide someone lacks capacity based on his or her appearance, age, condition or behaviour alone.

3.2 In order to decide a person has the mental capacity to make a decision you must decide whether there is an impairment or disturbance in the functioning of the person's brain – it does not matter if this is permanent or temporary.

3.3 If so the second question is does the impairment/disturbance make the person unable to make that particular decision? The person will be unable to make a particular decision after all appropriate help and support to make the decision has been given to them they cannot:

- Understand the information relevant to the decision including the likely consequences of making or not making the decision.
- Retain the information
- Use the information as part of the decision making process
- Communicate their decision by any means

3.4 An assessment must be made on the balance of probabilities and although more than likely the person does lack capacity you should be able to demonstrate in your records why you have come to that conclusion.

3.5 Sometimes your assessment may be challenged by another person acting for the individual such as a family member or advocate. Seek resolution in the following ways:

- Raise the matter with the person who made the assessment and check records.
- A second opinion may be useful.
- Involve an advocate but not an IMCA.
- Local complaints procedure.
- Mediation
- Case conference
- Ruling by Court of Protection

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4. Best Interests Assessment

4.1 If a person has been assessed as lacking capacity to make that decision then the decision made for, or on behalf of, that person, must be made in his or her best interests. A best interest's decision must be objective; it is about what is in the person's best interests and not the best interests of the decision maker.

4.2 The decision maker must weigh up all the factors involved, consider the advantages and disadvantages of the proposals and determine which course of action is the least restrictive for the person involved. This includes consideration of restriction or deprivation of liberty.

4.3 By best interests we mean:

- The decision maker has considered all relevant circumstances, including any written statements made while the patient had capacity must also be taken into account and any other information relevant to this decision
- Equal consideration and non-discrimination - not to make an assumption that a decision is made merely on the basis of a person's age or condition,
- The decision maker has considered whether the person is likely to regain capacity – can the decision be put off until then?
- Permitting and encouraging participation - the person has been involved as fully as possible in the decision, with the appropriate means of communication or using other people to help the person participate in the decision making process. Healthcare professionals are therefore required to make enquiries of relatives, carers and friends of the patient. Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be taken into account if the person had capacity, and to take into account, if practicable and appropriate the views of people who have formally or informally been involved with, or named by, the incapacitated person.
- Special considerations for life sustaining treatment - the decision maker is **NOT** motivated by a desire to bring about the person's death.
- Taking into account the views of any IMCA or Attorney appointed by the person or the Court of Protection.
- Consider whether there is a less restrictive alternative or intervention that is in the person's best interests.

4.4 When determining someone's best interests you must be able to demonstrate:

- That you have carefully assessed any conflicting evidence and
- Provide clear, objective reasons as to why you are acting in the person's best interests.

4.5 As far as possible try to ascertain:

- Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care?
- If practicable and appropriate you must consult with, and take in to account, the views of the following:
  - A Nominated Person
  - Lasting Power of Attorney appointed
  - Enduring Power of Attorney appointed
  - Court Appointed Deputy
  - Other persons engaged in caring for, or interested in, the person.

5. Challenging the Result of an Assessment of Capacity or Best Interests Decision

5.1 Your assessment of capacity may be challenged. It is important that everything you do is carefully documented.

5.2 It may be challenged in the following ways

- Raised directly with you
- Request for a second opinion

- Involving an advocate – NOT an IMCA
- Complaints procedure
- Court of Protection

5.3 **However** every effort should be made to resolve disagreements as informally as possible. Of importance are the following:

- How robust is the risk assessment?
- Has everything been recorded?
- Degree of 'contentiousness' of best interest decision between those involved in the person's care, i.e. the level of disagreement by family or IMCA as to proposed course of action?
- Is there a possibility of conflict of interest between family members and person, e.g. over finances?
- Urgency with which decision needs to be made?
- Degree to which decision/intervention can be reversed (undone)? The more irreversible, the higher the level of consultation required. Potential risks to the person and implications if a decision is made, not made or not reversed, including where other dependents are involved (e.g. children)

5.4 The Code of Practice makes it clear that any dispute about the interests of a person who lacks capacity should be resolved in a quick and cost effective manner.

5.5 Where significant persons are involved in the person's life every effort should be made to consult with, and involve, them and arrive at an agreed decision provided this is felt to be in that person's best interests and meets their assessed social and/or medical needs.

5.6 Where agreement cannot be reached seek assistance from your line manager or a senior manager in this process, further meetings may be necessary including seeking legal advice.

5.7 If no agreement can be reached the family or carers have recourse to the CCG complaints procedures of the agencies involved.

5.8 Recourse to the Court of Protection should be the last resort if no agreement can be reached. The equality and diversity lead should be consulted at this stage.

Appendix 2

Regulations

1 Regulations staff must be aware of:

- The Independent Mental Capacity Advocate
- The Office of the Public Guardian
- The Court of Protection
- Advance Decisions to refuse treatment
- Lasting Powers of Attorneys

2. The Independent Mental Capacity Advocate (IMCA)

2.1 Advocacy is taking action to help people:

- Express their views
- Secure their rights
- have their interests represented
- access information and services
- explore choices and options

2.1.2 Advocacy promotes equality, social justice and social inclusion. Therefore an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

2.1.3 Referrals to an IMCA must be considered when:

- There needs to be a decision relating to serious medical treatment.
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home)
- A long-term move to different accommodation is being considered for a period of over 8 weeks.
- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

2.1.4 If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. If it is urgent then the decision can be taken without an IMCA but they must be instructed afterwards.

2.1.5 If, after consultation with your line manager, you consider appointment of an IMCA would be of particular benefit to an individual then a referral must be made as outlined within appendix b.

2.1.6 It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

2.1.7 The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker.

3 The Office of the Public Guardian (OPG)

3.1.1 This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the COP, as requested.

3.1.2 The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. Application to search the registers is a fixed cost.

3.1.3 Further information regarding the Office of the Public Guardian can be found by the following link:
http://www.publicguardian.gov.uk/

4 The Court of Protection (COP)

4.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

4.1.2 The Act provides for a COP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (i.e. set examples to follow in future cases).

4.1.3 The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- appoint deputies to make decisions for people lacking capacity to make those decisions;
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties,
- and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

4.1.4 Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.

4.1.5 Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:
http://www.hmcourts-service.gov.uk/HMCSCourtFinder/

4.1.6 It must be stressed that any reference to the Court of Protection must be discussed with the Equality & Human Rights service in the first instance. The CCG must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. This is outlined in Appendix B.

5 Advance Decisions to Refuse Treatment (ADRT)

5.1.1 People may have given advance decisions regarding health treatments, which will relate mainly to medical decisions, these should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.

5.1.2 Making an advance decision to refuse treatment over the age of 18 years allows particular types of treatment you would never want, to be honoured in the event of losing capacity – this is legally binding and Health care professionals etc. must follow directions.

5.1.3 You must take all reasonable efforts to be aware of the advance decision and that it exists, is valid and applicable to the particular treatment in question.

5.1.4 The Act introduces a number of rules you must follow. Therefore a person should check that their current advance decision meets the rules if it is to take effect.

5.1.5 An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive, which without they may die) this must be in writing.

5.1.6 Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. You cannot ask for an advance decision to end your life or request treatment in future.

5.1.7 The validity of an advance decision may be challenge on the following grounds;

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act is the criteria for admission are met.
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision

5.1.8 To establish whether an advance decision is valid and applicable the healthcare professional must try to find out if the person:

- Has done anything that clearly goes against their advance decision.
- Has changed their mind and withdrawn their decision
- Has subsequently conferred the power to make that decision on an attorney, or
- Would have changed their decision if they had known more about the current circumstances.

6. Lasting Powers of Attorney (LPA)

6.1.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters
- Personal Welfare LPA re decisions about health and welfare, where you live, day to day care or medical treatment.

6.1.2 This must be recorded in the person's file where there is knowledge of it. It only comes into effect after the person loses capacity and must be registered with the Office of the Public Guardian. An LPA can only act within the remit of their authority.

7 Important facts about LPAs

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes an LPA they must have the capacity to understand the
  importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

8 Clinical Interventions

8.1.1 Decisions that are not covered by the MCA:

- Making a will
- Making a gift
- Entering into a contract
- Entering into litigation
- Entering in to marriage
- Sexual Relationships

8.1.2 There must always be an assumption of capacity; however procedural guidance at Appendix 1 tells a practitioner what to do if it is suspected that a vulnerable person lacks capacity to make a decision. This is called a Functional Capacity Test.

8.1.3 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf.

8.1.4 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation.

8.1.5 It is important to show that in assessing capacity you,

- have enabled a person, so far as is possible, to make their own decisions,
- have followed the five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity,
- have taken reasonable steps to establish lack of capacity,
- have reasonable belief that the person lacks capacity,
- have demonstrated their action will be in the person's best interest.

Section 5 of the Act offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity, provided they have followed due process. Appendix B covers the procedure required.