Mental Capacity Act Policy
Including Deprivation of Liberty Safeguards
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<tr>
<td><strong>TITLE</strong></td>
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<tr>
<td>Title: Mental Capacity Act Policy</td>
</tr>
<tr>
<td>Version: 1.1</td>
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<tr>
<td><strong>SUPERSEDES</strong></td>
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<tr>
<td>Supersedes: None</td>
</tr>
<tr>
<td>Description of Amendments: Updated to remove references to Designated Nurse and include Cheshire West ruling</td>
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<tr>
<td><strong>ORIGINATOR</strong></td>
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<td>Designation: Interim adult safeguarding lead</td>
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<td><strong>EXECUTIVE APPROVAL</strong></td>
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<tr>
<td>Approved by: Quality and Performance Committee</td>
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<tr>
<td>Date Approved: August, 2016</td>
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<tr>
<td><strong>EQUALITY ANALYSIS</strong></td>
</tr>
<tr>
<td>Date Completed: January 2014</td>
</tr>
<tr>
<td>Link to website: [to be completed once form is uploaded onto the CCG website]</td>
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<tr>
<td><strong>CIRCULATION</strong></td>
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<td>Issue Date: To be determined</td>
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<tr>
<td>Circulated by:</td>
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<tr>
<td>Issued To: (as per Circulation List)</td>
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<tr>
<td><strong>REVIEW</strong></td>
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<td>Review Date: July 2017</td>
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<td>Responsibility of: Interim adult safeguarding lead</td>
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<td>Chief Operating Officer</td>
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<td>Following Approval this Policy Document will be circulated to:</td>
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<td>Clinical Directors</td>
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## Glossary of Acronyms

- **DoLS** – Deprivation of Liberty Safeguards
- **MCA** – Mental Capacity Act
- **SAB** – Safeguarding Adults Board
1.0 Introduction

The Mental Capacity Act 2005 (MCA) is the legal framework for acting and making decisions on behalf of individuals who lack the capacity to make particular decisions for themselves. The MCA requires that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves, at the time the decision needs to be made.

The MCA overlaps with provisions made under the Children Act 1989 and 2004 in some areas.

Everyone working with or caring for an adult who may lack capacity to make a specific decision must comply with the Mental Capacity Act, irrespective of whether the decision relates to a life changing event or an everyday matter.

The MCA cannot be used for the following decisions:

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

This policy details the roles and responsibilities of the CCG as a commissioning organisation, with respect to mental capacity issues.

Relevant Legislation and Guidance

- The European Convention on Human Rights, 1956
- Children Act, 1989
- Human Fertilisation and Embryology Act, 1990
- Human Rights Act, 1998
- Mental Capacity Act, 2005
- Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- Mental Health Act, 1983 (amended 2007)
- Care Standards Act, 2003
- Children Act, 2004
2.0 Policy Statement

The CCG is statutorily responsible for ensuring that the organisations from which it commissions services provide a safe system which safeguards vulnerable children and adults, including adults who lack mental capacity.

The CCG will, therefore, ensure it commissions MCA compliant care and will ensure that providers meet their statutory responsibilities to people who are without capacity to consent to care and treatment.

The CCG will ensure that all relevant employees are aware of their responsibilities under the MCA and will ensure staff operate at all times in accordance with the MCA and the accompanying statutory code of practice.

3.0 Scope

When applying the MCA, certain categories of people are legally required to have regard to relevant guidance contained in the MCA code of practice.

These people include: ‘Anyone acting in a professional capacity for, or in relation to, a person who lacks capacity’ and ‘Anyone being paid for acts for or in relation to a person who lacks capacity’

This policy therefore applies to all staff directly employed by the CCG and will have implications for all commissioned services.

This policy aims to ensure that no act or omission by the CCG as a commissioning organisation puts an adult without mental capacity at risk and that robust systems are in place to safeguard and promote the rights of adults without capacity in commissioned services.

Where the CCG is identified as the lead commissioner it will notify associate commissioners of a provider’s non-compliance with their responsibilities with respect to mental capacity issues, or of any serious untoward incident that relates to mental capacity issues.

Where the CCG is identified as the associate commissioner it will reasonably expect to be notified by the lead commissioner of a provider’s non-compliance with their responsibilities with respect to mental capacity issues, or of any serious incident that relates to mental capacity issues. Similarly, it will inform the lead commissioner of a provider’s non-compliance with their responsibilities with respect to mental capacity issues or any serious incident that relates to mental capacity issues it identifies.

4.0 Definition

The Mental Capacity Act 2005 defines lack of capacity in the following way: “a person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”

Capacity is decision specific, in other words assessing capacity refers to assessing a person’s ability to make a particular decision at a particular moment in time, rather than being a blanket judgement about an individual’s ability to make decisions in general.
5.0 Basic Principles of the Mental Capacity Act

A person must be assumed to have capacity unless it is established that he/she lacks capacity.

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

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

Any action taken, or any decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.

Before any action is taken, or any decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person.

6.0 Accountability

Accountability and responsibility for compliance with CCG statutory responsibilities with respect to mental capacity sits with the Chief Operating Officer of the CCG.

The Chief Operating Officer delegates responsibility for compliance with CCG statutory responsibilities to the Chief Nurse. The Chief Nurse will ensure that the health contribution to promoting the rights and welfare of vulnerable adults without capacity is discharged effectively across the local health economy, through the CCG’s commissioning arrangements.

7.0 Responsibilities of the CCG

In order to discharge its responsibilities with respect to the Mental Capacity Act the CCG will:

Identify a named MCA lead and ensure that relevant policy, procedure and organisational structures support their role as MCA lead.

Ensure that all staff employed by the CCG are aware of their responsibilities with respect to the MCA.

The MCA lead is also available to support member practices and other NHS agencies within the local health system to be compliant with the act and the accompanying code of practice. Member practices will be required to provide assurances to NHS England (Greater Manchester Local Area Team) and the CCG that there are appropriate systems and process in place to support the implementation and use of MCA and DoLS. These will be audited annually as part of the safeguarding compliance audit. Other commissioned services will be required to provide assurances to the CCG that there are appropriate systems and process in place to support the implementation and use of MCA and its DoLS. These will be audited annually as part of the safeguarding compliance audit.

Ensure that training with regard to the mental capacity act and its effective implementation is available to CCG staff and member practices.

Develop a clear line of accountability for mental capacity matters, built into internal CCG governance arrangements.

Is a member of the local Adult Safeguarding Board and board sub-groups/work streams.
Work with local agencies to provide joint strategic leadership on MCA/DoLS in partnership with the Local Authority, provider clinical governance teams and safeguarding leads, CQC, and where applicable, the police.

Ensure that provider contracts specify compliance with MCA and DoLS legislation and that commissioned services are supported and contract monitored for compliance with MCA.

Ensure that learning from cases where mental capacity has been an issue will be used to inform future commissioning and practice.

Ensure that commissioning and other leads within the CCG have broad knowledge of healthcare for older people, people with dementia, people with learning disabilities, and people with Mental health problems.

Ensure that the local health and social care system influences local thinking and practice around MCA.

Ensure that best practice around mental capacity is promoted, implemented and monitored both within the CCG and within commissioned provider services.

8.0 Responsibilities of Providers

Provider organisations are responsible for: ensuring compliance with MCA legislation (including DoLS) within and across their organisation.

They must ensure that there is clarity as to who holds corporate responsibility for MCA and DoLS functions within the organisation, and that appropriate governance and safeguarding systems are in place to deliver best practice.

They must be in a position to provide assurance to CCG that responsibilities with respect to MCA are being safely discharged.

The CCG will oversee these responsibilities.

9. Mental Capacity Act Process

9.1 Who can make decisions?

A range of people may act as the decision maker on behalf of an individual who lacks the capacity to decide on an issue for themselves. The decision maker will be dependent on the type of decision which needs to be made.

In the context of health care decisions, the decision maker is most likely to be a registered practitioner.

For simple day-to-day decisions, a formal or informal carer may assist the individual to make a decision. If the individual is unable to make a decision for themselves, the formal or informal carer can do so on their behalf.

Where a decision is being made about placement usually a social worker will be the decision maker. However in CHC funded cases the Clinical Case Manager may be the decision maker.
Whoever the decision maker is, the ‘best interests’ guidance specified in the MCA and the Code of Practice must be followed.

The MCA provides a statutory basis for persons to be formally designated to make decisions on behalf of an individual who does not have mental capacity. See below. These named people will be the decision makers on issues where they have been formally given this power. It is essential that details of these named decision makers and the powers they have been granted are clearly recorded.

9.2 Lasting Powers of Attorney regarding health/welfare or property and affairs

From October 2007, an individual can create a Lasting Power of Attorney (LPA) while they have the relevant mental capacity.

LPAs enable an individual to grant authority to one or more persons and to make decisions on their behalf in relation to health, welfare, property or financial matters specified in the LPA document. These powers can include giving or refusing consent to medical examination and/or treatment as specified in the LPA.

Who can make a LPA?

- A person must be over 18 years
- Have capacity at the time to understand what he/she is doing
- Sign a written document that conforms with the statutory guidelines including information about the nature and effect of the LPA (specifies what powers are granted, and their limits)

For decisions regarding life sustaining treatment there must be:

- Specific authorizing statement in the LPA document
- Signed statement from the attorney and a certificate completed by an independent third party.

Full details of the process for making and registering an LPA are available on the Office of the Public Guardian Website at www.publicguardian.gov.uk/forms/registering-IPA.lpa

An essential component of the LPA application process is the completion of a ‘Provider's Certificate’ by an independent third party who may request payment for undertaking this role. This person needs to meet the individual making the LPA, without the intended Attorney present, in order to satisfy themselves that the individual:

- Understands the purpose of the LPA
- Is not under any pressure or coercion to create the LPA

Registered social workers are named in the MCA Regulations as persons able to witness an LPA and provide a Provider's Certificate. CCG staff may not complete a Providers' Certificate and should refer any request to Trafford Council.

The individual must register their completed LPA application with the Office of the Public Guardian (with the relevant fee). LPAs cannot be used until they have been registered.

Registered LPAs are easily identifiable as each page contains a holographic court seal.

How to check LPAs
• Check patients lacks capacity – if they do not lack capacity they make the decision for themselves
• Check the LPA is registered with the Office of the Public Guardian and is valid
• Ask to see the LPA document and make sure attorney has authorisation to make relevant decisions regarding health
• Check there is a specific statement authorising life sustaining treatment decisions
• If the team has concerns about the attorney they may proceed with treatment provided it is in the best interest of the patients and apply immediately to the Court of Protection for a decision.
• If the LPA is valid and applicable with no concerns about the attorney, the team must follow the decision of the attorney.

9.3 The Court of Protection and Court appointed ‘deputies’

If there is significant disagreement on the outcome of a capacity assessment or ‘best interests’ decision, or concern about the conduct of a person acting under an LPA, an application to the Court of Protection may be appropriate. The Court itself can make a decision, or it can appoint a ‘deputy’ to oversee relevant aspects of a case.

Also, relatives, local authorities or other people may apply to the Court to be appointed as deputy to enable them to make decisions on behalf of a person who already lacks mental capacity. In other words someone who no longer has the capacity to appoint an LPA.

Given the important decision-making roles of persons nominated under an LPA and court appointed deputies, it is vital that their details are clearly recorded in the medical notes and records kept up to date.

9.4 Advance decisions to refuse treatment

The Mental Capacity Act enables individuals who have capacity to set out their wishes to refuse named medical treatment should they lose the capacity at a future date. If an advance decision has been made, is valid and applicable, the instructions in it must be followed after the person has lost mental capacity, unless there are sound reasons to think that the individual had changed their mind subsequently.

People may have heard of terms such as ‘living will’ or ‘advance directive’. The MCA creates “advance decisions to refuse treatment”, however living wills and advance directives created prior to the implementation of the MCA should be taken as an advance decision.

CCG staff should make efforts to find out if a service user has made an advance decision. Details of any advance decision should be recorded in the individual’s clinical notes and be shared with GP and social care colleagues if the individual loses capacity.

A valid advance decision must specify the circumstances in which the refusal of medical treatments will apply and identify the medical treatment to be refused.
Any advance decision to refuse life-sustaining treatment must be made in writing and witnessed. It must also be specific about the circumstances in which it is intended to apply and include that the specified treatments are refused “even at risk of life”.

Details of any advance directive must be kept with the clinical notes and reference must be made to them within any care plans or when commissioning services for an individual.

9.5 Statement of wishes and preferences

Under the MCA, people making best interest decisions on behalf of a person lacking capacity must take into account that individual’s known wishes or preferences. These statements of wishes and preferences may have been written by the individual or shared verbally.

Unlike advance decisions, written statements or documented conversations are not binding on decision makers, but must be taken into consideration.

Details of written statements or relevant conversations the individual has had with family or carers should be recorded in their clinical notes.

9.6 Helping individuals to make their own decisions

The Act requires that all practical steps be taken to help someone make their own decisions before they are judged unable to make a decision.

Care and thought about the method of communication will help the individual to understand the nature of the decision and the choices available. Advice on the most effective means of communication can be sought from family, carers and/or others who know the individual well.

Information relevant to the decision should be explained to the individual using the form of communication which most appropriately meets the individual’s needs. Judgment will need to be exercised as to:

- The amount of information offered to the individual. Too much information can be confusing but insufficient information can mean that a decision cannot be reached.
- The use of simple language, avoiding jargon.
- The presence of relatives, friends or other people who are known to the individual.
- Communication aids.
- The most appropriate location for the individual. A familiar place is often the most suitable.
- The timing of the decision, as some people’s functioning may vary between different times of the day, or may be affected by particular medication.
- The presence of another person, to provide support in their decision making.
- The approach taken and the support provided should be recorded in the relevant medical notes. If the individual remains unable to make a decision, a mental capacity assessment should be undertaken and a best interests approach to decision making adopted on behalf of the individual.
9.8 Who should assess mental capacity?

- Every person working directly with service users in health and social care is likely to need to assess mental capacity at some stage. Generally, the person proposing a course of action or decision on behalf of the vulnerable person is regarded as the “decision-maker”.

- The best person to assess mental capacity is dependent on the setting and the decision which needs to be made.

- Within Trafford CCG clinical case managers, Mental Health Commissioners, Pharmacists, Customer experience and complaints staff or the Adult Safeguarding Lead are likely to identify complex decisions for which a formal capacity assessment will be required.

- Formal and informal carers will be best placed to assess a person’s capacity to make most day-to-day decisions (e.g. when to get up or what clothes to wear). This can take place at the time the decision needs to be made. In the main, this is unlikely to require formal assessment. If the individual has a care plan, the encouragement and support they require should be recorded in the care plan.

- Law practitioners will decide if a person has mental capacity to make decisions on legal matters, e.g. making a Will or a Lasting Power of Attorney. If they have doubts, they may request an assessment from a medical practitioner (Psychiatrist or GP as appropriate).

- **When consent for medical treatment or examination is required, the doctor proposing the treatment is the most likely person to decide whether the individual has the capacity to consent or refuse the treatment.** In complex cases, where there is no definitive diagnosis that would indicate impairment of mind or brain it will be necessary to refer to psychiatric services for assessment and diagnosis.

Please continue to next page
9.9 Assessing mental capacity to make decisions

Concerns about an individual's capacity to make a sound, informed decision

Assumption of capacity until proven otherwise

Clarify the specific decision in question

Take all practical steps to facilitate the individual to make the decision (e.g. provide information in relevant format, advocate, supporter, communication aids as highlighted in the capacity assessment guidance). Document those steps in designated clinical notes.

If concerns about capacity remain, check: Is there a deputy, a lasting POA, or an advance decision? The potential decision maker should undertake the assessment of capacity (refer to guidance and use assessment form).

Undertake capacity assessment

If assessed as incapacitous – proceed to the best interest decision phase. Record outcome on assessment form and in clinical notes

If assessed as capacitous – the individual's decision stands, even if it seems "unwise". Record outcome on assessment form and in clinical notes.

As 'decision maker', follow “Best Interest check list” (consult individual and all relevant parties) – recording best interest consultations and outcomes on Best Interest Decision Form and in the clinical record.

If there is disagreement on outcome of capacity assessment

A Mental Capacity Act conflict resolution meeting may be appropriate or a further capacity assessment may be undertaken.
9.10 Mental Capacity Assessment

The following two-stage test assists the decision maker to assess whether, on the balance of probability, the individual in question has the mental capacity to make a particular decision.

**Stage one** is to establish:

- Does the individual have the signs, symptoms or behaviours that indicate an impairment or disturbance in the functioning of their mind or brain (either permanent or temporary)? For example, they may appear very confused or have a previous diagnosis of dementia, have a learning disability, mental illness or have had a brain injury or be affected by substance misuse.

- If the answer to the above is ‘no’, the individual cannot be deemed to lack mental capacity under the Mental Capacity Act.

- If the answer to the above is ‘yes’, the next step is to establish if one or more of the options in **Stage two** apply as a result of the impairment or disturbance in the functioning of the individual's mind or brain.

**Stage two** is to consider if the individual is able:

- To **understand** the information relevant to the decision
- To **retain** that information (for long enough – this is a professional judgement)
- To **use or weigh** that information as part of the process of making the decision
- To **communicate** the decision (whether by talking, using sign language or any other means)

For some people, their ability to meet some or all of these criteria will fluctuate over time and it is therefore important that abilities to make decisions are reassessed regularly.

Some individuals, for example those in the early stages of dementia, are able to retain information for a limited period only. The fact that a person is able to retain the information relevant to a decision for a short period does not prevent him or her from being regarded as able to make the decision.

An individual may be competent to make certain decisions, but at the same time not have the capacity to make other, more complex decisions.

9.11 The mental capacity assessment form and recording

Assessments of mental capacity must be recorded when a patient appears unable to make a decision on a significant issue. This could include the management of finances, taking essential medication, maintaining adequate hydration and nutrition, agreeing to a package of care or change of accommodation.

**The Trafford mental capacity assessment form can be found by clicking the link to Trafford Adult safeguarding policies and procedures on the CCG website safeguarding page.**

It will not usually be necessary to document the assessment of a person’s capacity to consent to every day, low-risk interventions, such as providing routine assistance with personal care, beyond
the completion of care plans and nursing or therapy notes referring to the interaction with the individual and the care offered or given.

9.12 Acting in ‘best interests’

Any action undertaken or decision made on behalf of someone who lacks mental capacity must be undertaken or made in that individual's best interests.

Legal protection:

When enacting a decision in the ‘best interests’ of an individual, the person making the decision or carrying out an act will be protected from liability under Section 5 of the Mental Capacity Act provided they have:

- Followed the steps set out in the Act to establish whether the person has mental capacity in relation to the decision.
- Followed the steps set out in the Act to establish what the person’s best interests are.

9.13 The Statutory Best Interests Checklist

If an assessment of mental capacity establishes that an individual is not capable of making a particular decision, the decision maker must establish what action or decision would be in their best interests.

The ‘Best Interests’ checklist for decision makers set out in the Act can be summarised as follows:

Avoid discrimination

- Any decision about an individual’s best interests must be based on assessment, consultation and the establishment of information about them and their circumstances.
- Decisions must not be based on assumptions about the person’s age, condition, diagnosis or behaviour.

Encourage participation

- Permit and encourage the participation and involvement of the individual in the decision making process.
- As far as practical, use the style of communication that meets the individual's needs and choosing the optimum time of day and most suitable location.
- If capacity is fluctuating or may improve, (e.g. following treatment or medication), the decision-making process should be delayed to enable the person to make their own decision if at all possible.

Consider all relevant circumstances relating to the decision

- Take all reasonable steps to establish the person’s past and present wishes, values and beliefs about the issues.
• Consult anyone named by the person as knowing their wishes.
• Take into account the views of anyone engaged in caring for the person or interested in their welfare.

There are additional considerations if decisions involve the provision or withdrawal of life sustaining treatment. In these circumstances the Act clarifies that the decision maker must not be motivated by a desire to bring about the individual's death, even if they believe this would be in their best interests.

In cases where there are adult safeguarding concerns and the relatives, friends or representatives are implicated, it may not be appropriate to consult them. An IMCA must be appointed in these circumstances.

9.14 The best interests consultation process

The decision-maker needs to undertake consultation that is “practical and appropriate” to the particular decision being considered. The more significant and complex the decision, the more formal and wide ranging the consultation process should be.

People with a right to be included in best interests’ consultation include:

• Anyone named by the individual lacking capacity as someone to be consulted
• Anyone engaged in caring for the individual or interested in their welfare
• Any attorney appointed under a Lasting Power of Attorney
• Any deputy appointed by the Court of Protection
• An IMCA if the decision is about serious medical treatment or a change of residence and the individual lacking capacity is unbefriended (see section 15)

Ensure that a comprehensive record of any ‘best interests’ consultation is documented on the best interest decision form and the outcome recorded in the clinical notes.

The Trafford best interests form can be found by clicking the link to Trafford Adult safeguarding policies and procedures on the CCG website safeguarding page.

This includes a Do Not Attempt Resuscitation (DNAR) Best Interest Decision Form.

The best interests' assessment process must involve consideration of factors that have been important to the individual in the past, for example, how a certain decision may affect an individual’s close personal relationships or their ability to maintain a favourite activity.

9.15 DETERMINING BEST INTERESTS FLOWCHART
9.16 Reaching a decision
In many instances consultation will establish a consensus view about what is in the individual’s best interests. It is important that viewpoints and conflicting opinions are fully recorded in the service user’s records.

**The decision-maker** must work through the best interest ‘checklist’ and come to a determination of what is in the individual’s best interests.

The decision maker and resource allocation:

In relation to professional responsibilities under the Mental Capacity Act, there can only be one “decision-maker”. Therefore, within health care it can be the case that:

- **During the assessment/treatment planning stages.** the decision-maker is the GP, Hospital Consultant, Psychiatrist or Nurse (for nursing treatment)

- When a separate decision is required in relation to other aspects of health care provision, the decision-maker “baton” will need to be passed to the person responsible for making such decisions (e.g. Clinical Case Manager).

Taking resources into account within the best interests decision making process:

There is a close link between the concept of someone’s “best interests” and the requirement that any treatment or therapy plan should meet the person’s assessed needs. Any options that do not meet the individual’s assessed needs should be discounted as these can clearly be shown not to be in their best interests.

Case law related to the NHS and Community Care Act 1990 (the Gloucestershire and Lancashire judgments 1997) confirm that where a number of different care packages/options will meet assessed needs, the cost of different options may be taken into account as a part of the decision making process. Care can only be provided within existing, available resources.

Therefore, the more expensive option is not necessarily in the person’s best interests.

**9.18 Best interests and the use of restraint**

In certain circumstances, actions may be agreed as necessary which limit or restrict the liberty of an individual who lacks the capacity to understand the harm or injury their actions may cause. The Code of Practice gives examples to illustrate the range of issues of relevance to this key area.

In order to protect the rights of people who lack capacity, certain conditions must be met if an action is considered to be in an individual’s best interests but which may limit their rights and freedoms in some way.

Under the Act, any action which involves the restraint of an individual who lacks mental capacity is only lawful if certain conditions are met. These are:

- The person taking the action must **reasonably believe** that the restraint is necessary in order to **prevent harm** to the individual lacking capacity.

- Any restraint must be **proportionate** (both in degree and duration) to the **likelihood and seriousness of the harm** that is posed.
Strategies to manage risk will need to be agreed when an individual lacks capacity and their behaviour places them at risk of significant harm.

These strategies will need to be developed in consultation with the individual, their relatives, carers and representatives and the professionals responsible for their health and their care.

The healthcare professional in the Provider Organisation should discuss holding a planning meeting with their line manager and this should be chaired, where possible by the Nurse in Charge, Consultant Nurse/Therapist or Clinical Consultant.

CCG staff should not be directly involved in the restraint of individual patients, but may, where appropriate, contribute to planning meetings.

Where restraint meets the above criteria, the persons practicing the restraint will be protected against liability by the Mental Capacity Act. However where restraint leads to deprivation of liberty, then the MCA does not provide protection and authorization of the deprivation must be sought.

9.20 The Mental Capacity Advocate (IMCA) service

The Mental Capacity Act establishes an advocacy service to provide safeguards for people who:

- Lack capacity to make a specified decision at the time it needs to be made and;
- Are facing a decision on long term care in hospital (for more than 28 days) or a care home placement, or change of accommodation of more than 8 weeks duration, or in relation to serious medical treatment and;
- Have nobody else who is able and willing to represent them or be consulted in the process of working out their best interests.

Most individuals lacking capacity to make a specific decision will have family members or friends to support them. Any person considering a best interests decision for a person assessed as lacking capacity must consult these people.

If the individual is “unbefriended” an IMCA must be instructed to assist the decision maker when the decision involves one of the following:

- Providing, withholding or stopping serious medical treatment
- Moving an individual into long term care in hospital (i.e. for more than 28 days)
- Moving an individual to a residential or nursing home or other accommodation intended to continue for more than eight weeks
- Moving the individual to a different hospital or care home
- Representing the views of the patient in adult safeguarding cases

The role and function of IMCAs:

Under the MCA, local authorities have been required to arrange IMCA services in their geographical area using designated Department of Health grant monies. All IMCA services must
meet statutory regulations and each IMCA must have received training which meets national guidelines.

- Each IMCA scheme is responsible for providing a free IMCA service for individuals who meet the criteria (see above) and who live in or are staying in their geographical area (including as a hospital patient) at the time the serious decision is to be made.

- Therefore if a Trafford funded individual is placed outside the borough boundary, contact should be made with the IMCA service for the relevant area. The relevant local authority should provide contact details for the IMCA service funded by them.

- IMCAs must act independently of the person making the decision on behalf of the person who lacks capacity.

The role of an IMCA encompasses:

- supporting the individual who lacks capacity and following the 5 principles of the MCA

- obtaining the views of the professionals or paid workers who provide care or treatment to the individual and anyone else who can give information about the individual's wishes, feelings, values or beliefs

- finding out alternative courses of action that are available

- establishing what support the individual has received to assist them in decision making

- representing the individual who lacks capacity in discussions or meetings regarding the decision in question

- raising questions or challenging decisions which do not appear to be in the individual's best interests

- requesting access to the individual’s social care and/or medical records

- meeting the individual in private

- Preparing a report for the NHS or Local Authority decision-maker as soon as possible so that their report can form part of the decision making.

Referrals to the IMCA service

The IMCA service operates during 9am – 5pm Monday to Friday. The service does not operate at weekends or on Bank or Public holidays. It provides an advocacy service for any person meeting the criteria who is accommodated or placed within Trafford at the time the serious decision is requested to be made.

CCG staff who have identified a potential IMCA referral should complete an IMCA referral form and send it to Trafford Council who will arrange for an IMCA to be appointed.

Any IMCA referral should be clearly documented in the clinical notes stating date and time of referral

Facilitating IMCAs to access the records of individual service users:
IMCA’s have a statutory right to examine the records of individuals referred to them. IMCA’s will make themselves known to the patient and the record holder, they will explain the circumstances and why they need to access a patient’s records. The IMCA will have a recognised identity badge clearly displayed.

Access to records by an IMCA should be given the highest priority and be arranged to take place as soon as possible so that decisions about serious medical treatment and/or transfer from hospital or to a care home can be finalised.

Details of the IMCA access to records must be documented in the clinical notes.

9.21 The care and treatment of people who have a mental disorder

The Mental Health Act 1983 (MHA) and The Mental Capacity Act 2005 (MCA) have different purposes. The MCA has a broad scope and provides a legal framework for acting and decision-making which applies in many situations where adults are unable to make decisions and act for themselves.

The MHA provides a much narrower legal authority for the admission to hospital and treatment (where appropriate, without consent) of people with a mental disorder because of the risk posed to themselves or others.

The MCA does not apply to mental health treatment for people detained under the MHA, but still would apply to physical health treatment.

The Mental Health Act 1983 only deals with treatment “for mental disorder”. However, a person detained under the Mental Health Act may also lack capacity in relation to some other form of medical treatment or some other issues. For example, someone may be detained for treatment for a mental disorder but also require surgery. In these cases, the Mental Capacity Act will apply to decisions about surgery.

Chapter 13 of the Code of Practice contains detailed guidance for practitioners on the appropriate use of MHA and MCA, in relation to individuals who have a mental disorder (including the use of guardianship) and who are assessed to lack capacity. Practitioners must refer to the Codes for guidance on individual cases.

9.22 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards are dealt with in their own code of practice which is a supplement to the main Mental Capacity Act 2005 Code of Practice. This should be consulted for further guidance.

The DOL safeguards were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of HL v the United Kingdom3 (commonly referred to as the ‘Bournewood’ judgment). In this case a man with autism was admitted to a hospital. He lacked capacity to decide if he should be admitted or not. He was admitted under common law. His carers challenged his admission. The European Court of Human Rights ruled that all the factors of his ongoing admission amounted to a deprivation of liberty and that:

- It had not been in accordance with ‘a procedure prescribed by law’ and was, therefore, in breach of Article 5(1) of the ECHR, and
- there had been a contravention of Article 5(4) of the ECHR because HL had no means of applying quickly to a court to see if the deprivation of liberty was lawful.
The Mental Capacity Act 2005 has been amended to prevent further similar breaches of the ECHR. The amendments provide the necessary safeguards for people:

- who lack capacity specifically to consent to treatment or care in either a hospital or a care home; and
- the care can only be provided in circumstances that amount to a deprivation of liberty; and the care is in their Best Interest; and
- detention under the Mental Health Act 1983 is not appropriate for the person at that time.

These safeguards are referred to in this Code of Practice as ‘deprivation of liberty safeguards’.

The safeguards should not be viewed as a punitive or negative measure. Their aim is where ever possible to prevent a deprivation of liberty occurring. However, in some cases the duty to safeguard a person, without capacity to decide on relevant matters in their care plan, will mean that the circumstances of their care amount to an unavoidable deprivation of their liberty in their best interests. In these cases the DOLS ensure that this is for no longer than necessary, is as less restrictive as possible and provide significant safeguards for the person. They also provide clear guidelines and legal protection for those involved, including professionals and family.

As stated above, DOLS only apply to people in a hospital or care home; they do not apply to people in private residence; and they only apply to people over 18.

An authorisation under DOLS can only be made if it is:

- in the person’s best interests to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm, and
- if there is no less restrictive alternative.

It is important to bear in mind that, while the deprivation of liberty might be for the purpose of giving a person treatment, a deprivation of liberty authorisation does not itself authorise treatment.

Treatment that is proposed following authorisation of deprivation of liberty may only be given with the person’s consent (if they have capacity to make the decision) or in accordance with the wider provisions of the Mental Capacity Act 2005. If this treatment is for a mental disorder and it cannot be given under section 5 of The Mental Capacity Act (see above), then the provisions under The Mental Health Act 1983 should be considered.

9.23 What is ‘Deprivation of Liberty’?

The law draws a distinction between ‘a restriction of movement’ and a ‘deprivation of liberty’. A ‘restriction of movement’ does not need to be authorised under the DOLS provisions. However, the principles of the Mental Capacity Act 2005 apply to any restriction of movement. In particular, it should be necessary, in the person’s best interests, proportionate, and for as short a period as possible.

In March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council” which clarified whether arrangements made for the care and/or treatment of an individual lacking capacity to
consent to those arrangements amount to a deprivation of liberty for the purpose of Article 5 of the European Convention on Human Rights:

“The person is under continuous supervision and control and is not free to leave”

This definition is known as the “acid test”

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement or even in someone’s own home in the community. Such placements, or where there is likely to be such a placement, must be authorised by the Court of Protection.

At every stage of care planning professionals should be mindful of issues of capacity, promoting participation and reducing the level of any restriction to only what is necessary, proportionate and for a short a time as possible. This is particularly important within the context of a potential deprivation of liberty. This is a standard expected of all staff relevant to their level and should be a consistent approach throughout care planning and commissioning care.

9.24 Action to be taken if a deprivation of liberty is occurring or is likely to occur.

If CCG staff are concerned that a deprivation of liberty is or is likely to be occurring in an NHS Trust hospital or care home accommodation but not in a domestic setting then the issue should be raised immediately with the care team. The care team should consider what steps could be taken to prevent a deprivation of liberty.

If the care team believe a deprivation of liberty, is already occurring, cannot be avoided and the above criteria are met then the NHS Trust or care home, as the “managing authority”, will need to make an urgent authorisation to Trafford Council. This will also involve making a request for a standard authorization.

If the care team believe a deprivation of liberty is not yet occurring but is likely to occur, cannot be avoided and the above criteria are met then a request for a standard authorisation will need to be made to Trafford Council.

If there are concerns that a deprivation of liberty is occurring, the referral criteria for DOLS are not met and provisions under the Mental Health Act 1983 cannot be used then adjustments must be made to the care plan immediately by the care team to stop the restrictions amounting to a deprivation of liberty.

If CCG staff are concerned that an unauthorised deprivation of liberty is occurring or is likely to occur in an NHS Trust or care home accommodation then they should discuss their concerns with the managing authority of the home or hospital and inform their line manager as soon as is practicable.

10. Policy Review

The Mental Capacity Act Policy will be reviewed annually, and in accordance with the following on an as and when required basis:

- Legislative changes
- Good practice guidance
- Case law
- Serious Incidents
- Safeguarding Adults Reviews, (where applicable)
- Changes to organisational infrastructure
References

Mental Capacity Act, 2005 HMSO London
Mental Health Act, 2007, HMSO,London