Mental Capacity Act Policy
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1. Introduction

This document constitutes the local, Mental Capacity Act (MCA) operational policy for health and social care staff working for Achieving for Children.

The document is closely aligned to the local, multi-agency, Mental Capacity Act operational policy for health and social care staff working for The Royal Borough of Kingston upon Thames, Your Healthcare (YHC), NHS Kingston SWL Borough Team, Kingston Hospital NHS Trust (KHT) and South West London and St George’s Mental Health NHS Trust (SWLSTG). The joint policy was approved by the Safeguarding Adults Partnership Board and forms the basis of this policy.

We are grateful to Your Healthcare for advice and support in writing this policy from

This policy is intended for use with young people aged 16 and 17 years but there is some additional information added which relates to children under 16 years of age. The principle of involving people in decisions about their care, within their capacity to do so, is important for children of all ages.

The purpose of this guidance is to inform health and social care professionals about the local procedural arrangements for working with children with disabilities that may affect their mental capacity to make decisions and their families. This policy applies to all health and social care staff involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves, and also provides guidance for children under that age.

This policy should be read in conjunction with other relevant local policies and procedures specific to each employing organisation (for example, The Mental Capacity Act 2005, or other Safeguarding related policies).

1.1 Implementation

This policy will be made readily available on TriX (www.proceduresonline.com/achievingforchildren/chapters/docs_library.html#all_children).

It will be cascaded throughout organisations via relevant newsletters and through local area governance groups and at team meetings.

1.2 Audit and review

The operation of this policy will be monitored by the Clinical Governance Group on an annual basis.

1.3 Context

Before the MCA (2005) came into effect, finance and property related matters for people lacking the capacity to manage their affairs rested with the old Court of Protection. Enduring Powers of Attorneys were introduced in 1986 as a means by which individuals could choose who managed their property and finances if they lost capacity to manage their own affairs. However, a succession of cases in the years preceding implementation of the act demonstrated the need for an over-arching body of law to cover this group of vulnerable people and to protect their rights and freedoms.
The MCA (2005) was introduced in October 2007 to provide a comprehensive statutory framework covering personal welfare, healthcare and financial decisions affecting people who may lack capacity to make those decisions for themselves.

1.4 Key principles of the Mental Capacity Act

The basic principles of the MCA are described in this policy. However, for a detailed commentary on the practice implications of the law, staff will need to consult the act itself and the Code of Practice, as well as case law commentary as it emerges.

Staff will need to keep the following five key principles in mind when working with people who may lack capacity to make decisions. Statutory organisations need to have reporting arrangements to demonstrate that they are working to these principles:

- **Presumption of capacity**: a person must be assumed to have capacity unless it is established that they lack capacity to make a decision.
- **Maximising decision-making**: a person is not to be treated as unable to make a decision unless all practical efforts to help them have been made without success.
- **Unwise decisions**: a person is not to be treated as unable to make a decision merely because they make an unwise decision. The code of practice advises that there may be cause for concern and a need for further investigation if a person repeatedly makes unwise decisions, or makes a decision that is irrational or out of character.
- **Best interests**: an act done or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in their best interests.
- **Less restrictive option**: before an act is done or a decision is made on behalf of a person lacking capacity it should be considered whether the purpose for which it is needed can be achieved in a way that is less restrictive of that person’s rights and freedom of action (but the option chosen must be in the person’s best interests).

1.5 Key terms relating to the act

- **Capacity test**: standard test to assess a person’s capacity based on the decision-making process that can be used by professionals and non-professionals alike.
- **Best interests**: the basis on which all decisions must be made on behalf of people who lack capacity to make their own decisions.
- **Decision-maker**: the person who requires the particular decision to be made.
- **Advance decisions**: legal mechanism to allow people with capacity to plan ahead and make future decisions to refuse medical treatment to apply at a time when they may lack capacity to consent to or refuse the proposed treatment.
- **Lasting power of attorney (LPA)**: people with capacity can make an LPA, appointing another person (or persons) to make care, treatment and/or financial decisions on their behalf in the future when they lack capacity to make those decisions for themselves. They replace the previous system of enduring powers of attorney (EPAs) although EPAs made before the act came into effect will continue to be valid.
- **Independent Mental Capacity Advocacy Service**: provides independent mental capacity advocates (IMCAs) to represent and safeguard the interests of the most vulnerable people affected by the Act.
- **Court of protection**: the judicial body that will act as the main adjudicator on disputed and complex decisions concerning the act.
- **Deputies**: people appointed by the Court of Protection to make decisions on behalf of people who lack capacity, replacing the former court appointed receivers.
- **Public guardian**: maintains a register of lasting powers of attorneys and supervises the work of deputies. The Office of the Public Guardian (OPG) replaced the Public Guardianship Office.
- **Criminal offence**: the act introduces two new criminal offences - ill-treatment and wilful neglect of a person who lacks capacity to make relevant decisions.

### 2. Information for managers and staff

Staff are reminded that they have a formal duty to be knowledgeable about the act and the code of practice, and will need to take active responsibility for equipping themselves to practice within the law. They should also be able to explain how they take into account the act and the code when acting or making decisions on behalf of people who lack capacity to make decisions themselves.

Staff will also need to ensure that they consider the equality principles of the nine protected characteristics (age, disability, gender reassignment, sex, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation.

#### 2.1 Responsibilities of managers

- Managers are responsible for ensuring their staff are aware of this policy and that staff adhere to the information and guidance within.
- Managers must ensure that staff are made aware of this policy on induction to their organisation.
- Managers will support their teams and staff and will facilitate training and ensure that staff are able to access training that directly relates to this policy.

#### 2.2 Responsibilities of staff

- Staff are obliged to adhere strictly to this policy and are responsible for ensuring they identify training to meet their needs and access relevant training.
- Staff will attend related training and will ensure they apply for all required training according to organisational policy.
- Failure to comply with the standards detailed in this policy may lead to disciplinary procedures against them.

#### 2.3 Training

Training will be available locally. Staff must ensure they apply for MCA training as per local requirements – currently on appointment to post and refreshed every three years for health staff.

### 3. Procedures

#### 3.1 Assessment of capacity

The act sets out a single test for assessing whether a person lacks capacity to take a particular decision at a particular time, based on the principles outlined above. If a person has a diagnosed
learning disability this does not imply or determine that they lack capacity. The act simplifies assessment of capacity and encourages this to be undertaken by a wide range of health and social care staff on a regular basis. More detailed assessments of capacity will remain within the remit of specialist professionals, mainly medical or psychology professionals in the context of formal capacity assessments, such as for the purposes of court reports, and for other specialised contexts requiring a more detailed assessment, although the principles of the act will still apply to these assessments.

The starting point for assessing someone’s capacity to make a particular decision, where they are over 16 years of age, is always the presumption that the individual has capacity. The Court of Protection has ruled that in circumstances where an interim order or directions are needed from the court, but a full assessment of the person’s capacity has not been possible, then the court will act if there is evidence giving ‘good cause for concern’ that the person may lack capacity to make a relevant decision (Ref [2009] EWHC B30 (Fam) at 44).

3.1.1 Defining lack of capacity

The MCA (2005) provides a statutory framework to empower and protect vulnerable people who may not be able to make specific decisions themselves. The act defines lack of capacity as an inability to make a particular decision at a particular time due to ‘an impairment of, or disturbance in the functioning of, the mind or brain’. The act imposes the following requirements when defining capacity.

- **Decision specific**: capacity relates to a specific decision not a general ability to make decisions.
- **Time specific**: whether a person can make a decision at the time the decision needs to be made.
- **Diagnostic threshold**: a person must have permanent or temporary impairment, or disturbance in the functioning of, the mind or brain which causes them to be unable to make the decision in question.
- **Not based on age, appearance, or any condition or aspect of a person’s behaviour**: such as a learning disability, acquired brain injury, dementia, acute care needs, etc.
- **Balance of probabilities**: lack of capacity must be decided on the balance of probabilities of what is more likely than not.

The act states that a person cannot make a decision if they cannot do any of the following four things:

- understand information relevant to the decision (the information must be given to the person in a way that is appropriate to their particular circumstances, using the best means of communication)
- retain that information long enough to be able to make the decision
- use or weigh up the information available to make the decision as part of the decision-making process
- communicate their decision (whether by talking, using sign language or any other means).

Lack of capacity can, for example, be due to any of the following if that condition causes the person to be unable to make the decision in question.

- A stroke or brain injury
- A mental health problem
• A learning disability
• Confusion, drowsiness or unconsciousness because of an illness or the treatment of it
• A neurological disorder
• Alcohol or substance misuse.

The act further emphasises that an impairment of, or disturbance in the functioning of, the mind or brain can be permanent or temporary. It says that no-one can be labelled ‘incapable’ by reference simply to a particular diagnosis or mental condition nor by reference to a person’s age or appearance or aspect of their behaviour that might lead to an unjustified assumption about their lack of capacity.

3.1.2 Who makes assessments under the act?

All professionals working with adults in health and social care will probably have to assess capacity at some stage. Who assesses capacity depends on the nature of the particular decision that needs to be made. For day-to-day domestic decisions, a carer can assess the person’s capacity to consent to the care being offered and take decisions relating to those acts of care, based on the person’s best interests at the time that the decision needs to be made. Health and social care professionals working with adults will also make assessments of capacity and make best interests decisions on a day-to-day basis.

However, more experienced professionals with specialist skills may need to become involved when more formal assessments of capacity are required. The code of practice suggests that an expert opinion may be needed when:

• a decision needs to be made that is serious or has serious consequences
• there is a dispute about capacity between the person concerned or by carers or other professionals
• the person being assessed is expressing different views to different people, perhaps in an attempt to tell them what they think they want to hear
• a challenge to a person’s capacity to make a decision is likely
• there are legal consequences to a finding of capacity
• a person is repeatedly making decisions that put them or others at risk of harm
• capacity is an issue in a case of adult safeguarding

The act does not specify which professionals should undertake assessments or make decisions. Primarily, it is the person who requires a decision who will need to assess the person’s capacity to make the decision themselves.

3.1.3 Children and young people under 16 years of age

Young people aged 16 or 17 are presumed to have capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. See section 3.1.4.

“Children under the age of 16 are presumed to lack capacity, but can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. Otherwise someone with parental responsibility can consent for them.” (NHS choices)
The SEN Code of Practice (2014) states that young people over compulsory school age have a right to participate in decisions about care and provision and can ask their parents or others to help them make decisions.

In AFC children’s service, there is a commitment to involve young people in decisions about their care and in determining the goals they would aspire to. Although not a legal requirement under the act, the service seeks to involve children and young people of all ages as much as possible and as far as they are able within the levels of their abilities. This might involve making everyday choices for themselves in the early stages, but also includes involvement in agreeing goals for intervention that meet their aspirations.

For children, the legal position for decision making about their needs and intervention, rests with the person who has legal parental responsibility.

The service seeks to ensure that the views of the child or young person are heard and taken into account in developing care plans for children and young people.

- Children’s and young peoples’ views should be sought separately to the views of parents.
- Children’s and young peoples’ views should be recorded in case records separately from the parents (even when in agreement).
- Where there is a difference, staff should discuss these with parents and children.
- Where children and young people have a particular view, staff should explain how intervention and care plans fit with the child or young person’s aspirations.

3.1.4 Gillick and Fraser competency

Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to those under 16 without parental consent. Since the original case, the guidelines have been used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions in a wider context.

In 1982, Mrs Victoria Gillick took her local health authority (West Norfolk and Wisbech Area Health Authority) and the Department of Health and Social Security to court in an attempt to stop doctors from giving contraceptive advice or treatment to under 16 year olds without parental consent.

The case went to the High Court in 1984 where Mr Justice Woolf dismissed Mrs Gillick’s claims. The Court of Appeal reversed this decision, but in 1985 it went to the House of Lords and the Law Lords (Lord Scarman, Lord Fraser and Lord Bridge) ruled in favour of the original judgment delivered by Mr Justice Woolf.

"...whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent" (Gillick v West Norfolk, 1984).

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Lord Fraser stated that a doctor could proceed to give advice and treatment provided he is satisfied in the following criteria:
the girl (although under the age of 16 years of age) will understand his advice

he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice

she is very likely to continue having sexual intercourse with or without contraceptive treatment

unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer

her best interests require him to give her contraceptive advice, treatment or both without the parental consent. (Gillick v West Norfolk, 1985)

Lord Scarman’s comments on his judgement of the Gillick case in the House of Lords (Gillick v West Norfolk, 1985) are often referred to as the test of ‘Gillick competency’:

"...it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."

He also commented more generally on parents’ versus children’s rights:

"Parental right yields to the child’s right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

Whilst the Fraser guidelines refer specifically to contraceptive advice, it is important to consider children’s and young peoples’ views for other areas of healthcare and to understand that they may have sufficient maturity and understanding to form an opinion that is different to that of those with parental responsibility.

3.1.5 Assessment of capacity

Anyone assessing someone’s capacity to make a decision for themselves should use the two stage test of capacity based on the statutory definition of capacity described above (para 2.1).

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

If so, does the impairment or disturbance mean that the person is unable to make that specific decision when they need to?

An assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. The impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

the loss of capacity is partial (the person may lack capacity to make a decision about one issue, but not about others)

the loss of capacity is temporary

their capacity changes over time.

Assessment of capacity is not required for under-16s, but staff should follow good practice and involve the child or young person in assessment, planning and intervention decisions.
3.1.6 Assessing ability to make a decision

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

- understand information about the decision to be made (the act calls this relevant information)
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

Relevant information includes the particular nature of the decision, the purpose for which the decision is needed, and the likely consequences of deciding one way or another or of making no decision at all.

3.1.7 Court judgments on the assessment of capacity

In cases coming before the Court of Protection, the court has confirmed that capacity is both decision-specific and time-specific, but identifying what is the specific decision in question and the information relevant to the decision, is not always straightforward. For example, in Re S: D v R (Deputy of S) and S [2010] EWHC 2405 (COP) concerning capacity to continue legal proceedings, the court found that the decision was ‘a complex one which requires a good deal of detailed information and self-awareness’. In A Local Authority v Mrs A [2010] EWHC 1549, concerning the capacity of a woman to make decisions about contraceptive treatment, the court found that the ability to foresee the realities of parenthood was too remote from the medical issue of contraception to be a relevant factor for making the decision. However, in financial transactions dealing with significant amounts of money, the nature of the decision and the likely consequences may be easier to identify.

Guidance on what is required to use or weigh the relevant information has been given by the court in The PCT v P, AH & The Local Authority [2009] EW Misc 10 (EWCOP) where it was described as the ability ‘actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another’.

3.1.8 Helping people to make their own decisions

The act requires that all practicable steps are taken to help someone make their own decision, before they can be regarded as unable to make that decision.

Whilst the act does not apply to under-16s, the following should be considered when communicating with a child or young person who has the capacity to understand the decisions to be made.

- All information relevant to the decision must be explained to the person.
- A judgement should be made by the person giving the information, as a balance must be struck between giving insufficient information to make a decision and giving too much information or detail which could be confusing.
- Care and thought about the most effective method of communication will help the person to understand the nature of the decision and the choices available.
- Simple language should be used, avoiding jargon. Use of pictures or objects could be helpful. Interpreters should also be used.
- Family, carers and others who know the person well, can advise on the most effective methods of communication with the person.
- The presence of relatives, friends or other people who know the person can help communication.
- Communication aids may be necessary.
- Most people find it easier to make decisions when they are in an environment where they feel more at ease.
- Consider the most appropriate location for the person. A familiar place is often the most suitable, if practicable.
- Consider 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 person may benefit from having the support of another person, to provide support in their decision-making.

3.1.9 When should capacity be assessed?
It is important to carry out an assessment when a person’s (over 16 years) capacity is in doubt. It is vitally important that the person who carries out an assessment can justify their conclusions. Someone who is assessed as lacking capacity may be denied their right to make a specific decision, particularly if others think that the decision would not be in their best interests or could cause harm. Also, if a person lacks capacity to make specific decisions, they might make decisions they do not really understand which could cause harm or put the person at risk.

3.1.10 Assessment and recording of capacity
This guidance offers a multi-agency functional test for capacity: the FACE mental capacity assessment tool (appendix 2). This tool can be used as a stand-alone capacity report for the purposes of formal recording or as an addendum to specialist reports.

To have the capacity to make a decision someone must be able to:
- understand the information relevant to the decision; and
- retain the information; and
- use or weigh the information to arrive at a choice; and
- communicate the decision.

3.2 Best interests
Once a person is assessed as lacking capacity to make a decision, the act requires that anyone carrying out acts in connection with the person’s care or treatment, or making decisions on their behalf, must always act in the person’s best interests. The act sets out a checklist of factors that must always be taken into account when determining best interests and detailed guidance is given in the code of practice. The FACE Mental Capacity Assessment provides additional guidance for decision-makers in the determination of best interests and with regard to the key statutory criteria. It also acts as a record that staff are reasonably acting in the best interests of vulnerable people.
3.2.1 Best interests check list

To determine what action or decision would be in a person’s best interests, the decision-maker must:

- **encourage participation**: do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

- **identify all relevant circumstance**: try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

  - **find out the person’s views**: try to find out the views of the person who lacks capacity, including:
    - the person’s past and present wishes and feelings. These may have been expressed verbally, in writing or through behaviour or habits;
  - any beliefs and values (religious, cultural, moral or political) that would be likely to influence the decision in question
  - any other factors that the person themselves would be likely to consider if they were making the decision or acting for themselves

- **avoid discrimination**: not make assumptions about someone’s best interest simply on the basis of the person’s age, appearance, condition or behaviour

- **assess whether the person might regain capacity**: consider whether the person is likely to regain capacity (for example, after receiving medical treatment). If so, can the decision wait until then?

- **assess whether the decision concerns life sustaining treatment**: not be motivated in any way by a desire to bring about the person’s death. They should not make assumptions about the person’s quality of life

- **consult others**: if it is practical and appropriate to do so, consult other people for their views about the person’s best interest and to see if they have any information about the person’s wishes and feelings, beliefs and values.

In particular try to consult:

- anyone previously named by the person as someone to be consulted on either the decision in question or in similar issues;
- anyone engaged in caring for the person;
- close relatives, friends or others who take an interest in the person’s welfare;
- any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person;
- any deputy appointed by the Court of Protection to make decisions for the person.

For decisions about major medical treatment or where the person should live and where there is no one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

When consulting, remember that the person who lacks capacity to make the decision or act for themselves still has the right to keep their affairs private, so it would not be right to share every piece of information with everyone
• **avoid restricting the person’s rights**: see if there are other options that may be less restrictive of the person’s rights

• **take all of this into account**: weigh up all of these factors in order to work out what is in the person’s best interest

There are times when a joint decision might be made by a number of people. For example, when a care plan for a person who lacks capacity to make relevant decisions is being put together, different healthcare or social care staff might be involved in making decisions or recommendations about the person’s care package. Sometimes these decisions will be made by a team of healthcare or social care staff as a whole and other times, the decision will be made by a specific individual within the team. A different member of the team may then implement that decision, based on what the team has worked out to be the person’s best interests.

3.2.2 Court judgments on best interests

The Court of Protection has confirmed that there is no hierarchy in the best interests checklist. The weight to be attached to the various factors will depend on the specific circumstances, although in any particular case, one or more factors may be of ‘magnetic’ importance (Re M, ITW v. Z & Ors [2009] EWHC 2525 (Fam)).

The weight to be given to the person’s own wishes and feelings has been considered by the court in a number of cases. In C v V, Re S and S (protected persons) [2008] EWHC B16 (Fam), the court held that the person’s wishes should be followed unless they are irrational, impractical, or irresponsible (with reference to resources), or there is some potentially detrimental effect for the person of not doing so. The need to give great weight to the person’s wishes was confirmed in Re P [2009] EWHC 163 (Ch) although in this case the court confirmed that this did not necessarily mean those wishes must always be followed (they are not paramount). Further guidance on this aspect of the best interests checklist is given in Re M, ITW v. Z, M and Ors [2009] EWHC 2825 (Fam) and in Re GC [2008] EWHC 3402 (Fam).

In Re M, ITW v. Z, M and Ors [2009] EWHC 2825 (Fam) Mr Justice Munby suggested that in determining best interests, it may be appropriate to consult with former carers and to take into account oral statements made by the person who lacks mental capacity. However, the Senior Judge of the Court of Protection has held that where consultation with family or carers is likely to be unduly onerous, contentious, futile or serve no useful purpose, it is not practicable or appropriate. (Re Allen [2009] (CoP No 11661992) (unreported))

All of the above court judgments on determining best interests were reviewed in Re G (TJ) ([2010] EWHC 3005 (COP). In particular the court considered how to determine someone’s best interests when contemplating a step which was of no direct benefit to the person themselves, including how the court should take into account what their wishes were likely to have been. In that case the court decided that it was in the person’s best interests for their deputy to make maintenance payments from the funds to the adult daughter.

3.2.3 Best interests and advance decisions

If the person has previously made an advance decision to refuse specific medical treatment and it is now proposed to give that treatment, the advance decision must be followed if it applies to the circumstances that have now arisen and the person now lacks capacity to consent. This will override the need to carry out a best interest assessment.
However, if the person has made an advance statement setting out their wishes and preferences with regard to medical treatment (as distinct from refusing specific treatment), then the statement must be taken into account as one of the factors in the checklist to be considered when determining whether the treatment is in the person’s best interests (See appendix 1 for full details).

3.2.4 Recording outcomes

It is a statutory requirement for professionals to carry out a proper assessment of a person’s capacity to make particular decisions. It is also good practice that staff record the findings in the relevant professional records. As stated the FACE Mental Capacity Assessment tool is to be used for this purpose, with the exception of Kingston Hospital NHS Trust staff who will be following their internal procedures.

Any outcomes of a mental capacity assessment must be made explicit on care plans. For example, carers who are required to make daily decisions in connection with the care or treatment of service users must as far as possible involve them in decisions and ensure the decisions are made in the person’s best interests.

Assessments of capacity to make day-to-day decisions or consent to care require no formal assessment procedures or recorded documentation, although it is considered good practice for paid care workers to keep a record of the steps they take when caring for the person.

3.2.5 Formal reports or certificates of capacity

In some cases, a more detailed report or certificate of capacity may be required, for example:
- for use in court or other legal processes
- as required by regulations, rules or orders made under the Act.

4. Legislation in connection with care or treatment

4.1 Protection from liability for caring acts

The act lays out a system of protection against legal liability, where a person is providing care or treatment for someone who lacks capacity to consent to that care or treatment. The key is proper assessment of capacity and best interests. This protection covers actions that could otherwise result in a civil wrong or crime if someone has to interfere with the person’s body or property in the ordinary course of caring. For example, acts of physical assistance with personal care or hygiene, help with eating and drinking, carrying out a medical or dental examination or giving treatment, shopping or buying goods with the person’s money. A longer, but not exhaustive list of acts covered by protection from liability is contained in the code of practice of the act. Such actions can be performed as if the person concerned had capacity and had given consent.

In general, people providing care or treatment have no need to obtain any formal powers or authority to act, so long as they are acting in the person’s best interests, although some types of serious medical treatment (such as non-therapeutic sterilisation or the withdrawal of artificial nutrition or hydration) will always need to be authorised by the Court of Protection (see section below).

However, the act imposes some important limitations on acts that can be carried out with protection from liability. For example, a carer or healthcare professional who is acting unreasonably, negligently or not in the person’s best interests could forfeit that protection. In
particular, there will be no protection where restraint is used unnecessarily or inappropriately on someone who lacks capacity, or where the person is deprived of their liberty.

4.2 Restraint, restriction and deprivation of liberty

The act defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm. In such circumstances, only the minimum necessary force or intervention may be used and for the shortest possible duration.

While it may be permitted to restrict someone’s liberty to protect them from harm, additional safeguards need to be put in place if the restrictions imposed on the person amount to depriving them of their liberty. In the case of HL v United Kingdom, also known as the Bournewood case, the European Court of Human Rights held that proper legal procedures must be followed where a person with mental disorder is cared for or given treatment in conditions that amount to a deprivation of their liberty.

Amendments to the MCA (2005), introduced by the Mental Health Act 2007, set out the legal procedures required to authorise deprivation of liberty of a person who lacks capacity to consent, if that is in the person’s best interests. These provisions, which came into force in April 2009, permit someone to be deprived of their liberty under the Act in one of three situations:

- where the deprivation is authorised by the Court of Protection
- where the deprivation is authorised in accordance with the deprivation of liberty safeguards (DOLS) set out in the act
- in an emergency, where deprivation of liberty is necessary in order to give life-sustaining treatment or treatment to prevent serious deterioration in the person’s condition while a decision is sought from the court.

These procedures apply not only to hospitals, but also to residential and nursing homes that care for mentally incapacitated residents (such as people with dementia or a learning disability), where the care plan involves preventing the person from leaving the home and other restrictions which may result in a deprivation of liberty.

4.3 When someone lacks capacity and objects to intervention

There may be circumstances where a person whose capacity is in doubt refuses to undergo an assessment of capacity or refuses to be examined by a professional.

Objections to particular actions can take different forms, from physical resistance to verbal objections, passive resistance and other non-verbal responses. It is not possible, nor would it be appropriate to be prescriptive regarding how to respond to objections, and how to attempt to overcome them. Examples may be:

- a person who is incontinent is reluctant to wear pads
- a person with diabetes refuses their insulin injection.
In these circumstances, skilled and sensitive responses from the member of staff will frequently (but not always) enable the task to be completed. Clear and ongoing communication with the service user is likely to help enable cooperation.

The effect of the failure to provide the particular intervention will vary with the nature of the care or treatment. In some circumstances, the effect will be gradual and/or restricted to reducing the service user’s quality of life for example, cleaning or washing. Other examples will have a faster and more drastic effect, such as declining to eat or to accept insulin.

Consideration must always be given to the likely effect of the failure to provide the planned care or treatment, to the person, their environment and to those around them. Wherever possible, family members and others concerned with the person’s welfare should be consulted. This will help determine the urgency of the decision-making needed regarding implementation of the care plan.

It is imperative that in circumstances where an incapacitated service user is refusing or resisting care or treatment, discussions are held with senior staff to consider how to ensure the appropriate care is delivered. If necessary, these discussions should include the wider care team.

If there are serious worries about the person’s mental health, it may be possible to get a warrant to force entry and assess the person for treatment in hospital, but the situation must meet the requirements of the Mental Health Act 1983 Section 135 (1). Simply refusing an assessment of capacity is in no way sufficient grounds for an assessment under the Mental Health Act 1983.

In A Local Authority v A (Re A (Adult) and Re C (Child)) [2010] EWHC 978 (Fam), Lord Justice Munby gave guidance to local authorities on how to exercise of their powers concerning the welfare of adults lacking capacity to consent. He stressed that ‘the local authority is the servant of those in need of its support and assistance, not their master’ and warned against the mind set of some local authorities seeking to exercise control, citing examples of the removal of incapacitated adults from the care of their relatives into residential accommodation without the sanction of the court and therefore, in some cases, without any legal authority.

4.4 Charging and protection of property

Section 7 of the Mental Capacity Act allows for a person or organisation carrying out acts in connection with the care or treatment of a person lacking capacity to consent (under Section 5) to organise the supply and payment of goods or services considered necessary for people lacking capacity to make these arrangements themselves. ‘Necessary’ is defined as being appropriate to the person’s condition in life and actual requirements at the time. Goods and services might be taken therefore to reflect anything needed to maintain the person or their property, from food and medicines to paying utility bills and to clearing blocked drains or repairing a leaky roof.

Section 8 of the act allows the person or organisation organising those goods and services to commit expenditure on the person’s behalf or to reimburse themselves from the person’s money if they have spent money themselves in an urgent situation. Guidance for staff advises that they should not under any circumstances use their own money to fund expenditure, but should use appropriate service budgets.

There is no explicit government guidance to date regarding the local authority charging people who lack capacity to agree to a care package or to any other similar decisions, apart from those liable to Section 117 of the Mental Health Act 1983. When arranging care packages, local authority
staff will need to incorporate capacity and best interest’s considerations in their paperwork as the act asks them to take reasonable steps to ascertain capacity, consent and best interests.

Where a person or organisation needs to be reimbursed for money they have spent on a service user’s behalf, they may need to apply to someone who has lawful control over the service user’s money such as an attorney, deputy or appointee. The right of a person or organisation either to be reimbursed for expenditure they have incurred themselves or committed on the service user’s behalf, does not in any way change the powers that an attorney, appointee or deputy might have over the service user’s money.

4.5 Lasting powers of attorney

Before the Mental Capacity Act came into effect, a person with capacity could make an enduring power of attorney (EPA) to appoint an attorney (or attorneys) to make decisions about the property and financial affairs of the donor (person making the power of attorney) after the donor has lost mental capacity to manage their own financial affairs. EPAs made before 30 September 2007 remain valid, but no new EPAs were made after that date as the act has replaced EPAs with a new type of power of attorney, the lasting power of attorney (LPA). This is one of the main ways in which the act allows people to plan for future incapacity.

By making a lasting power of attorney, the donor can appoint their chosen representative(s) to make decisions on their behalf when they no longer have capacity to make their own decisions. There are two types of LPA: one covers decisions about property and financial affairs, the second covers decisions about personal welfare, which could include healthcare and consent to medical treatment for people who lack capacity to make such decisions for themselves. Different attorneys may be appointed to take different types of decisions. Health and social care professionals therefore need to be familiar with LPAs and must respect the powers delegated to attorneys to make decisions on the donor’s behalf.

There are two statutory forms for making an LPA: one for property and affairs and one for health and welfare decisions. Each form must include a certificate signed by an independent person, confirming that, at the time of making the LPA, the donor understands what is involved and has not been put under undue pressure to make the LPA. An LPA must be registered with the public guardian before it can be used. A property and affairs LPA can be used, with the donor’s consent, while they still have capacity to make financial decisions. However, a health and welfare LPA can only be used when the donor lacks capacity to make the decision in question.

Only adults aged 18 and over can make a lasting power of attorney. Attorneys of an LPA must also be at least 18. For property and affairs LPAs, the attorney must not be bankrupt at the time they are made an attorney and, if the donor wishes, the attorney could be a trust corporation (often parts of banks or other financial institutions). At the time of making an LPA, the donor can choose to name a replacement attorney (or attorneys) to take over in the case that their original attorney(s) are no longer able to act for them.

Attorneys acting under a lasting power of attorney have a duty to:

- follow the Mental Capacity Act’s statutory principles
- make decisions in the donor’s best interests
- have regard to the guidance in the code of practice
- only make those decisions the lasting power of attorney gives them the authority to make.
Anyone who has concerns that an attorney is not acting properly should report the matter to the office of the public Guardian (see later section on the public guardian).

4.6 Expressing wishes and preferences regarding care or treatment

Some people may wish to record their wishes and preferences regarding care and treatment in the form of general statements made in advance while they still have capacity. These can cover a wide range of preferred treatments or ways in which people would prefer to be cared for if they lose capacity. It is recommended that these are written down and health and social care staff should take care to lodge these accessibly in the patient or service users’ notes.

It should be noted however, that these statements can be withdrawn or altered while the person still has capacity to do so and that they need not be in writing. Staff should consider adding a planning ahead element to user or patient reviews such as care programme approach reviews.

These general wishes and preferences should be taken into account by those providing care and treatment in the future when the person no longer has capacity to express these views at the time. They will be relevant in considering what course of action would be in the person’s best interests, but such wishes and preferences are not binding. However, the act allows people to make advance decisions to refuse treatment which are binding and must be followed so long as they are valid and applicable in the particular circumstances.

4.7 Advance decisions to refuse treatment

The act now clarifies the legal position allowing people to make an advance decision to refuse medical treatment which has the same force as a contemporaneous refusal of treatment. An advance decision enables someone aged 18 and over, while still capable, to refuse specific medical treatment, intending that refusal to apply at a time in the future when the treatment is proposed and they may lack the capacity to consent to or refuse that treatment. It is only possible to make an advance decision to refuse treatment; it is not possible to specify or request that a treatment be given. Similarly, no one can ask for or receive procedures that are against the law, such as help with committing suicide.

The code of practice provides detailed guidance on the right of those over 18 to specify what treatments they wish to refuse in the future should they lack capacity to do so at the time that treatment is proposed. Information on consent to treatment, including treatment decisions made by young people (under the age of 18) is available at:


The act imposes specific safeguards for advance decisions refusing life-sustaining treatment, which must:

- be in writing (it can be written by someone else at the person’s direction or be recorded in the healthcare notes)
- be signed by the person making the decision (or if they are physically unable to do so, by someone else at the person’s direction)
- be witnessed
- state clearly that the decision applies even if life is at risk.
There is no set form for written advance decisions because contents will vary according to the person’s wishes and their particular situation. The code of practice suggests that it would be useful to include the following information:

- full details of the person making the advance decision (date of birth, home address and any distinguishing features, to help with identification should the person be unconscious)
- name and address of GP and whether they have a copy of the document
- a statement that the document should be used if the person ever lacks the mental capacity to make a decision about the treatment specified in the advance decision
- a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply
- the date the document was written (and, where appropriate, when it was reviewed)
- the person’s signature (or the signature of someone the person has asked to sign on their behalf and in their presence)
- the signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person’s behalf)

For an advance decision to be binding at the time when it is proposed to carry out or continue the specified treatment, there must be proof that the advance decision exists, and that it is both valid and applicable to the proposed treatment.

The person making an advance decision is responsible for making arrangements to ensure that the existence of the advance decision is drawn to the attention of a doctor or other healthcare professional whenever it may be needed. This could be done by asking for the advance decision to be recorded in their healthcare records, providing their GP with a copy of any written document, carrying a card or wearing a bracelet indicating the existence of an advance decision. Family members may also know whether their relative has made an advance decision. However, emergency treatment should not be delayed to search for an advance decision if there is no reason to believe that one exists.

The act confirms that an advance decision is not valid if the person:

- has subsequently withdrawn the advance decision while still capable
- has subsequently made an LPA giving an attorney authority to make the decision in question
- has since acted inconsistently with the advance decision (for example, by consenting to treatment previously refused in the advance decision or by converting to a new religion which may affect their views on medical treatment).

An advance decision is not applicable if:

- the proposed treatment is not the treatment specified in the advance decision
- the circumstances are different from those specified in the advance decision
- new circumstances have arisen (such as the development of new treatments or changes in personal circumstances) which were not anticipated by the person when making the advance decision and which might have affected the decision.

Therefore, in deciding whether an advance decision is valid and applicable, healthcare professionals must try to find out if the patient:
• has done anything that clearly goes against their advance decision
• has withdrawn their decision
• has subsequently conferred the power to make that decision to an attorney
• would have changed their decision if they had known more about the current circumstances.

Clinicians at Kingston Hospital would be expected to check with the Head of PALS Complaints and Litigation prior to implementing an advance decision if they have any concerns about the existence, validity or applicability of the advance decision.

Advance decisions to refuse treatment for a mental disorder may be overridden if the person who made the advance decision is, or is liable to be, detained under the Mental Health Act 1983. However, an advance decision refusing treatment for a physical condition is not affected by the person’s detention under the Mental Health Act.

Apart from an advance decision to refuse life-sustaining treatment, an advance decision does not have to be in writing and can be verbal. It is recommended in the code of practice that healthcare professionals should record a verbal advance decision in the person’s healthcare record, thereby creating a written record which could prevent confusion about the decision in the future.

Such a record in the healthcare notes should include:
• a note that the decision should apply if the person lacks capacity to make treatment decisions in the future
• a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply
• details of someone who was present when the oral advance decision was recorded and the role in which they were present (such as a healthcare professional, family member)
• whether they heard the decision, took part in it or are just aware that it exists.

People are able to alter or cancel their advance decisions at any time while they have the capacity to do so. This can be done verbally, in writing or by tearing up the original advance decision.

Advance decisions made before the act came into force (October 2007) may still be valid and applicable. Healthcare professionals should apply the rules in the act to advance decisions made prior to the act coming into force, subject to the transitional protections that will apply to advance decisions that refuse life-sustaining treatment.

Further guidance is available on: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_079670.pdf

Advance decisions have considerable implications for healthcare professionals.

4.8 The code of practice responsibilities

The code of practice highlights the following responsibilities to:
• determine whether a patient it is proposed to treat has refused such treatment in advance
• understand that valid and applicable advance decisions to refuse treatment have the same legal status as decisions made by people with capacity at the time of treatment
• discuss treatment options with patients and to ascertain if there are any specific types of treatment they do not wish to receive if they ever lack the capacity to consent in the future
• make reasonable efforts to find the advance decision if told that one exists for a patient currently lacking the capacity to consent (reasonable efforts might include talking to relatives of the patient, looking in the clinical notes and contacting the patient’s GP)
• ensure the advance decision is valid and applicable in the current circumstances to the treatment being proposed
• take extra care in trying to establish the patient’s wishes where the advance decision has not been reviewed for a long time and the patient’s current circumstances are considerably different from those when the advance decision was made (extra care might include discussing the position with people close to the patient, or anyone named in the advance decision)
• follow the advance decision if satisfied it exists, is valid and applicable
• treat the patient if not satisfied that an advance decision exists, is valid and is applicable. Treating the patient can be undertaken without fear of liability provided the treatment is done in the patient’s best interests and the decision to treat is recorded explaining why the advance decision was considered invalid or not applicable.

A healthcare professional must provide treatment in the patient’s best interests, unless they are satisfied that there is an advance decision that is valid and applicable in the current circumstances.

Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists, but if it is clear that the patient has made an advance decision that is likely to be relevant they should assess its validity and applicability as soon as possible. This has to be balanced by the urgency of the treatment decision.

Where there is ongoing dispute with relatives or within the multidisciplinary team or between consultants about the validity or applicability of an advance decision, the matter can be referred to the Court of Protection to resolve the dispute.

Health and social care staff should also bear in mind the potential advantages an advance decision and/or a lasting power of attorney have in enabling those suffering from a potential degenerative condition to take decision, whilst they still have capacity, about how they would like to be treated when they lack capacity. Staff should make patients aware of this facility afforded by the Mental Capacity Act.

4.9 Disputes

The code of practice gives general guidance on how to resolve disputes and conflicts about issues of capacity. Local authority and NHS staff should seek local resolution of disputes, concerns and challenges rather than risking expensive legal processes. In the first instance in the local authority, the Mental Capacity Act senior practitioner or in the NHS, the relevant line manager should provide an overview and support to resolve disputes. If this is unsuccessful then the relevant local authority or NHS service head or service manager will convene a case review and reconciliation process with help from the respective legal section. Different agencies should be aware of their own dispute and reconciliation processes.

The Court of Protection is the final arbiter on matters of capacity or disputes affecting people who lack capacity. In cases where there is an ongoing need for decisions (either relating to the person’s welfare or their financial affairs) to be made on behalf of someone lacking capacity, the court may appoint a deputy with authority to make such decisions (see section 23 below).
5. Public Guardian, Court of Protection and deputies

The act has established two public bodies to support and implement the law affecting people who lack capacity:

- the Public Guardian
- the Court of Protection

5.1 The public guardian

The public guardian and the office of the public guardian (OPG) have been established under the act to promote and protect the financial affairs, health and welfare of people who lack mental capacity, in conjunction with the Court of Protection. The OPG is an executive agency of the Ministry of Justice.

The office of the public guardian also has a role in protecting vulnerable people from abuse, by:

- setting-up and managing a register of lasting powers of attorney and enduring powers of attorney (to ensure they meet the act’s requirements)
- setting-up and managing a register of court orders that appoint deputies
- supervising deputies
- sending Court of Protection visitors to visit people who may lack capacity to make particular decisions and those who have formal powers to act on their behalf
- receiving reports from attorneys acting under lasting powers of attorney and from deputies
- providing reports to the Court of Protection as requested
- dealing with representations or complaints about the way in which attorneys or deputies carry out their duties, working with other relevant organisations such as social services.

The public guardian has a specific responsibility to investigate concerns or complaints made about any attorney or deputy. The investigation may be carried out jointly with another agency such as the NHS or a local authority as appropriate.

Staff who are concerned that an attorney or deputy is not acting in the best interests of a person lacking capacity can request action by the office of the public guardian. Such a decision should be made after careful examination of the situation and involve the multidisciplinary team where appropriate, and be reported to the public guardian by a senior member of staff.

5.2 Court of Protection

The new Court of Protection replaces the previous court of the same name. It has wider powers, which include:

- making declarations, decisions and orders on financial, health and/or welfare matters affecting people who lack, or are alleged to lack, capacity (the lack of capacity must relate to the particular issue being presented to the court)
- where there is a need for ongoing decision-making, appointing deputies to make particular decisions for people who lack capacity to make those decisions
- resolving issues concerning the use or validity of LPAs
removing deputies or attorneys who act inappropriately

making a will on behalf of someone who lacks testamentary capacity.

In deciding what type of order or decision to make, the court must apply the act’s principles and make a decision in the best interests of the person lacking capacity. Where possible, in welfare or healthcare matters, the court should make the decision itself in preference to appointing a deputy. However, a deputy will often need to be appointed to make ongoing decisions affecting the person’s property and financial affairs (similar to the appointment of a receiver in the past).

The Court of Protection also has to provide authority for certain serious healthcare and treatment decisions. Cases which involve any of the following decisions should always be brought before the court as they are considered so serious that they cannot be left to attorneys, deputies or healthcare staff.

- The proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- Cases involving organ or bone marrow donation by a person who lacks capacity to consent
- Cases involving the proposed non-therapeutic sterilisation of a person who lacks the capacity to consent to this (for example, for contraceptive purposes)
- All other cases where there is a doubt or dispute about whether a particular treatment will be in the person’s best interests.

5.3 Deputies

Where the court believes that there is a need for ongoing decision-making powers for a person lacking capacity to make financial decisions or very rarely, welfare decisions, it may appoint a deputy to make such decisions on the person’s behalf. This is similar to the appointment of receivers by the previous Court of Protection. The court must first be satisfied that the matter before it, cannot be resolved by a less restrictive approach, by making a single order or decision, and that the appointment of a deputy is in the person’s best interests. The court decides who to appoint as deputy (often a family member but sometimes a professional) and the order of appointment will set out the particular decisions or actions the deputy is authorised to take. The Code of Practice sets out the duties and responsibilities of deputies.

In cases where the court may decide to appoint a local authority office holder to act as a deputy, decisions must always be made in the best interests of the person concerned and care must be taken to avoid possible conflicts of interest.

6. Confidentiality, disclosure and consultation

Health and social care staff are required to work within the five principles of the act. In particular, they must take all practical steps to help people make their own decisions, including for example to maximise people’s ability to consent to the disclosure of personal information which may be relevant to their care or treatment. However, people who lack capacity to consent retain the right to have their confidentiality respected.

Health and social care staff may disclose information about somebody who lacks capacity to consent only when it is in the person’s best interests to do so or when there are other lawful reasons to do so. Chapter 16 of the MCA Code of Practice gives a detailed commentary.
It is noted that independent mental capacity advocates (IMCAs) have a statutory right of access to relevant patient or user documentation. This includes secure data systems, where there would be an expectation that staff support the IMCA to access relevant information.

7. Independent Mental Capacity Advocates

7.1 Referral to Independent Mental Capacity Advocate (IMCA) Service

The act places a legal duty on local authorities and the NHS to refer a person to a service in certain circumstances in order to support vulnerable people who lack capacity to make important decisions. The Independent Mental Capacity Advocate Service was created to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends with whom it would be appropriate to consult about those decisions. IMCAs work with and support people who lack capacity, and represent their views to those who are working out whether the proposed treatment or change of accommodation is in their best interests. IMCAs may also need to be involved in care reviews or in safeguarding adult procedures.

7.1.1 Aim of the IMCA Service

The aim of the IMCA Service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no one else (other than paid staff) to support or represent them or be consulted.

It is for the decision-maker to decide whether the person has any family, friends, attorneys or other people whom it would be appropriate to consult about the decision in question. If the person has made an LPA or where a deputy has been appointed by the court, it may only be appropriate to consult an attorney or deputy with authority to make personal welfare decisions, not those who only make financial decisions, unless there are other reasons to consult them (for example, if they are family members). It may not be appropriate to consult family members who have little contact with the person. If family members disagree with the proposed decision that alone is not sufficient grounds for concluding that it is not appropriate to consult them. But if there is reason to believe they are not acting in the person’s best interests, or there are other reasons why it would not be practical or appropriate to consult them, this should be recorded and an IMCA must be instructed.

7.1.2 Instructing an IMCA

An IMCA must be instructed, and then consulted, for people lacking capacity who have no one else to support them (other than paid staff), whenever:

- an NHS body is proposing to provide, withhold or withdraw serious medical treatment
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or in the care home for more than eight weeks. (Sometimes a person’s placement will be longer than expected. The responsible body should involve an IMCA as soon as they realise the stay will be longer than 28 days or eight weeks).
Where social services is preparing to arrange accommodation or change accommodation in a care home for more than eight weeks, the referral to the IMCA is the responsibility of the care manager.

The IMCA must be instructed and the IMCA’s report must be taken into account before the decision is made. The only exception to this is in emergency situations where an urgent decision is needed.

**Discretion to instruct an IMCA:** there is also a discretionary power to instruct an IMCA in relation to two further types of decisions, where the decision-maker considers this may be of benefit to the person lacking capacity. An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no one else is available to be consulted
- adult protection (safeguarding adults) cases involving a person lacking capacity (who may be either the alleged victim or abuser), whether or not family, friends or others are involved (see 19.4 below).

The IMCA will:

- be independent of the person making the decision
- provide support for the person who lacks capacity
- represent the person without capacity in discussions to work out whether the proposed decision is in the person’s best interests
- provide information to help work out what is in the person’s best interests
- raise questions or challenge decisions which appear not to be in the best interests of the person.

The information the IMCA provides must be taken into account by decision-makers whenever they are working out what is in a person’s best interests and before the decision is made.

Following a referral to the IMCA service the decision-maker must:

- let all relevant people know when an IMCA is working on a person’s case
- must obtain a written report from the IMCA on their findings
- record an IMCA’s involvement in a case and any information the IMCA provides to help decision making
- record how the decision-maker has taken into account the IMCA’s report and information as part of the process of working out the person’s best interests (this should include reasons for disagreeing with that advice, if relevant)
- inform the IMCA of the final decision taken and the reason for it.

Ultimately, it is the decision-maker’s responsibility to decide whether a proposed course of action is in the person’s best interests. The decision-maker must take account of the reports made and information given by the IMCA. A decision on the person’s best interests will be made through discussion involving all the relevant people who are providing care or treatment, as well as the IMCA.
7.2 Involving IMCAs in adult protection (safeguarding adults) cases

You must consider instructing an IMCA to support and represent a person who lacks capacity where it is alleged that:

- the person is being or has been abused or neglected by another person
- the person is abusing or has abused another person.

You can only instruct an IMCA if you propose to take, or have already taken, protective measures. The action to be taken is set out in local multi-agency ‘Safeguarding adults: policy and procedure’.

In safeguarding adult cases (and no other cases), access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity, who have family and friends, can still have an IMCA to support them in the safeguarding procedures, if the investigating care manager, in consultation with their manager, is clear why it would be appropriate.

Where the allegations or evidence give rise to the question of whether the person who lacks capacity should be moved in their best interests, an IMCA must be involved if there is no one else appropriate to support and represent the person in this decision.

7.3 Advocacy Support – IMCA referral process and procedure

In Kingston upon Thames the IMCA service is provided by Kingston Advocacy Group (KAG). Once it has been identified that an individual will require an IMCA the process for referral to KAG must be followed. In Richmond upon Thames the advocacy service is provided by Richmond Aid.

7.4 IMCA data - monitoring and review

Arrangements have been made to ensure that data related to the age, disability, gender, ethnicity, religion or belief and sexual orientation of service users who are referred to the IMCA service can be collated and subsequently reviewed.

8. Children and young people

Note: The term ‘children’ is used for people under the age of 16, and ‘young people’ for those aged 16 and 17.

8.1 The MCA and children under 16

In most situations the care and welfare of children under 16 will continue to be dealt with under the Children Act 1989.

There are two parts of the MCA that apply to children under 16.

- The Court of Protection’s powers to make decisions concerning the property and affairs of a child under the age of 16. The court can make these decisions where it considers it likely that the child will lack capacity to make decisions about their property and affairs even when they are 16. This could be useful as it means there will be no need for new proceedings once the young person reaches adulthood. The arrangements made for them as a child can continue smoothly past the age of 18.
The criminal offence of ill treatment or neglect also applies to children under 16 who lack capacity as no lower age limit is specified for the victim (see 8.2 below). It remains to be seen whether there will be any advantages in prosecuting someone under this law rather than under existing laws used to protect children.

Care and treatment of children under 16 will remain generally governed by common law principles.

8.2 The MCA and young people of 16 and 17

Most of the provisions of the MCA apply to young people once they are 16. There are exceptions and the following parts of the MCA do not apply to 16 and 17 year olds, but only to people who are 18 and over.

- Making a lasting power of attorney
- Making an advance decision to refuse treatment
- Making a will. The law generally does not allow people under 18 to make a will and the MCA confirms that the Court of Protection has no power to make a will on behalf of anyone under 18.

The Code of Practice provides guidance on acts of care and treatment for young people who lack capacity to consent as well as background guidance about care and treatment for competent young people.

8.3 Young People who will need an IMCA

Young people, aged 16 and 17 must be referred to the IMCA service if they:

- lack capacity in relation to a decision
- are facing major or life changing decisions as defined in the IMCA guidance in this policy
- have no family member, friend or existing advocate who can support them in making a decision in their best interests.

8.4 Young people who already use an advocacy service

Some young people who lack capacity and who have no family or friends able to support them appropriately will often already be using an advocacy service. Many of these young people will be either children in need or looked after children.

Local authorities have a duty to provide an advocacy service for all looked after children and young people in need and in receipt of aftercare (Adoption Act 2002 amendment to Children Act 1989). In addition, all looked after children who do not have regular contact with their parents will have an independent visitor. It will remain within the professional judgement of the decision-maker on a case-by-case basis to decide whether the connection with these advocates is sufficiently robust to constitute an appropriate support for an otherwise ‘unbefriended’ young person facing the sort of decisions that might require an IMCA.

Should an IMCA be required then the IMCA will be provided by the local authority approved IMCA service.
8.5 Transitions

Transitions staff should act in accordance with the five principles of the act and Chapter 12 of the code of practice when helping young people to prepare for transition into adult services and plan for their future.

8.6 Working with parents who may lack capacity

Health and social care staff working with children and young people whose parents may lack capacity in relation to important decisions will need to be aware of the principles of the act and the code of practice. They may consider that the parents will need additional help to make decisions or have decisions made for them in their best interests.

9. Interface with the Mental Health Act

9.1 General

In general, for people who are detained and receiving treatment for their mental disorder under Part 4 of the Mental Health Act 1983, that act takes precedence over the Mental Capacity Act in relation to decisions concerning that treatment. However, if a detained person who lacks capacity to consent requires medical treatment for a physical illness or condition then a decision to commence treatment must be made in their best interests, in accordance with the principles and provisions of the Mental Capacity Act.

Detention of a person under the Mental Health Act is not an indicator of their incapacity. Treatment for mental disorder of a person lacking capacity to consent can take place outside of hospital, or following informal admission or with the consent of an LPA or deputy following a best interest’s decision-making process under the MCA 2005.

9.2 Shared principles

- Shared emphasis on inclusion, empowerment
- Partnership working
- Least restrictive practice
- Taking account of statements of wishes and feelings
- Ethical practice in defining Best Interests (MHA Code of Practice)

9.3 Detained people

- The MHA takes precedence over the MCA but only in relation to powers of treatment for mental disorder under Part 4 of MHA. It is therefore possible to treat persons under the MCA who are detained under MHA Sec 4, 5(2), 5(4), Sec 7, Sec 135, Sec 136.
- Advance decisions that are applicable and valid still apply unless they relate to treatment for mental disorder given under the MHA.
- Second opinion appointed doctor (SOAD) provisions apply under the MHA.
- An IMCA is not required for formal admissions to hospital under the MHA or to a care home under guardianship.
- Nearest relative powers remain and are distinct from LPA or a deputy.
9.4 Non-detained people in mental health hospital wards

- The MCA cannot be used as an alternative mode of admission where the criteria for the MHA apply and when the patient objects.
- A person lacking capacity who is not objecting and who is not being deprived of their liberty can be treated without recourse to the MHA.
- Care and treatment cannot conflict with the valid authority of the LPA or deputy.
- MCA can provide protection from liability where the principles of the act and best interests procedure are complied with and the MHA does not apply.
- IMCA provision may apply.

The act repeals Part 7 of the MHA 1983 in regard to receivership arrangements and replaces these arrangements by finance deputies (see 23.3 above).

10. Criminal offence

The MCA created two new criminal offences, ill-treatment or wilful neglect of a person who lacks, or is believed to lack, capacity to make relevant decisions. Conviction for such an offence could lead to a sentence of imprisonment (for a maximum of five years) and/or fine.

The offence has a wide application to anyone who has the care of a person lacking, or reasonably believed to lack, capacity. This includes not only family carers, but also health and social care staff in hospital or care homes or providing domiciliary care. It also applies to attorneys acting under an EPA or LPA and to any deputy appointed by the Court of Protection for that person.

In R v Dunn (2010) All ER (D) 250 (Nov), the court considered the meaning of a person who lacks capacity since this is not defined in MCA 2005 in the context of the criminal offence of ill-treatment. This case involved alleged ill-treatment by staff of residents in a care home for people suffering from dementia. The court held that despite the lack of a clear definition, it was open for the jury in this case to conclude that decisions regarding care had been made because the victims lacked capacity and such decisions had resulted in ill-treatment.

11. Research

This policy or procedure document requires all Achieving for Children, YHC, local authority and NHS staff to abide by the guidelines on research identified in the act and the code of practice.

The act recognises that it is important that research involving people who lack capacity to consent to their participation is carried out properly, and that it is needed to help staff improve their knowledge of how people lose capacity, and their ability to diagnose, treat and care for people who lack capacity.

Those conducting research have to make the same assumption as other professionals that everybody has capacity unless assessed otherwise using the framework contained within the act for assessment and for determining best interests. The person lacking capacity has the right to refuse to take part in research and should be helped to make a decision as far as their lack of capacity allows.
The research to which the act applies is:

- intrusive research (where if the person had capacity, the researcher would need to get their consent to take part, therefore the act applies)
- involves people who have an impairment or disturbance in the functioning of their mind or brain which renders them unable to decide whether or not to take part in the research in question.

It is not a clinical trial covered under the Medicines for Human Use (Clinical Trials) Regulations 2004.

There are situations which apply to the whole population where consent to be included in research is not required whether the person has capacity or lacks capacity. These situations are:

- where the data has been anonymised so confidentiality and data protection legislation does not apply
- if human tissue is being used and has been anonymised provided the research has had ethical approval and the tissue is from a living person
- if the human tissue samples were collected before 31 August 2006, although ethical approval will normally have to have been given
- issues covered by section 251 of the NHS Act 2006 which allows people to use confidential information without breaking the law on confidentiality, by applying to the patient information advisory group for approval on behalf of the Secretary of State.

Research covered by the act can only include people who lack capacity where it:

- has the approval of the appropriate body and
- follows the other requirements in the act to:
  - consider the views of carers and other relevant people
  - treat the person’s interests as more important than those of science and society
  - respect any objections a person who lacks capacity makes during research.

Research involving people who lack capacity also has to meet two further requirements.

- It must have some chance of benefiting the person who lacks capacity and the benefit must be in proportion to any burden caused by taking part. Potential benefits could include:
  - developing more effective ways of treating the person or managing their condition
  - improving the quality of healthcare, social care or other services to which the person has access
  - discovering the cause of their condition, if they would benefit from that knowledge
  - reducing the risk of the person being harmed, excluded or disadvantaged

- The aim of the research must be to provide knowledge about the cause of, or treatment or care of people with, the same impairing condition or a similar condition.
For the research to qualify under this second condition it must also ensure that:

- the risk to the person is negligible
- there must be no significant interference with the freedom of action or privacy of the person
- nothing must be done in relation to the person which is unduly invasive or restrictive.

12. References

Mental Capacity Act - Code of Practice

Further information on the Mental Capacity Act in its entirety can be found in the Code of Practice which is available at: www.publicguardian.gov.uk/mca/code-of-practice

Health and social care staff should note that they must be aware of the guidance in the code of practice when acting in a professional role in relation to service users who may lack capacity to make specific decisions for themselves.

The Mental Capacity Act (2005) Online

The Mental Health Act (2007) Online

Mental Capacity Act Code of Practice
www.publicguardian.gov.uk/mca/code-of-practice

Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse. SCIE January 2011.

Mental Capacity Act Resource Pack – MENCAP

A Child’s Legal Rights, Gillick Competency and Fraser Guidelines – NSPCC
Appendix 1 and 2

Is there a care treatment decision to be made?

Yes

Have all practical steps been taken to help the person make this decision for themselves?

No

Provide more support

Yes

Assess capacity: two stage test

Record outcome: does the person Have capacity to make this decision

Yes

The person’s decision must be respected

No

At the time of making the decision, does the person have anyone, other than paid staff, to help support or represent them, or to be consulted regarding the decision?

Yes

Is the decision about serious medical treatment, or a change in care home or hospital accommodation?

No

Consult LPA attorneys, deputies, carers And anyone interested in the person’s welfare

Yes

Is the person consulted an attorney or deputy with authority to make this decision

No

Appoint an IMCA to support and represent the person

Take the IMCA’s report into account

Apply best interests checklist

Consider if there is a less restrictive option?

Determine what is in the person’s best interests

Record outcome

Make the decision in the person’s best interests
FACE Mental Capacity Assessment

What prompted this assessment? *(I.e. summary of relevant history)*

Details:

What is the specific decision to be taken? *(If this is a review, detail previous decision about capacity)*

Details:

<table>
<thead>
<tr>
<th>Key roles</th>
<th>Closest person</th>
<th>Lasting Power of Attorney (LPA) – health and welfare</th>
<th>Enduring Power of Attorney (EPA)/LPA – financial</th>
<th>Court of Protection Deputy (CPD)</th>
<th>Other</th>
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<tbody>
<tr>
<td>Name</td>
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<td>Tel. No.</td>
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<tr>
<td>Role</td>
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**Determination of capacity** *(This is a specific, not general determination. Note any documentation referenced)*

Is there an impairment of or disturbance in the functioning of the person's mind or brain?  
- [ ] Permanent impairment
- [ ] Fluctuating impairment
- [ ] Temporary impairment
- [ ] No

Details:

Is the person able to understand information related to the decision?  
- [ ] Yes
- [ ] No

Details:

Are they able to retain information related to the decision?  
- [ ] Yes
- [ ] No

Details:
## Capacity Assessment Summary

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Are they able to use or weigh the information whilst considering the decision?</td>
<td></td>
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<tr>
<td>Are they able to communicate their decision by any means?</td>
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<tr>
<td>Were all reasonable steps taken to maximise the person’s capacity to make the decision?</td>
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<tr>
<td>Can the decision be delayed because the person is likely to regain capacity in the near future?</td>
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</table>

A ‘No’ answer in any of the 4 domains above constitutes incapacity. If all ‘Yes’ go to Assessment Summary.

## Decision Making

- **Advance decisions to refuse treatment** *(Note any documentation referenced)*
  - Is there an advance decision relevant to the decision? | No | Yes |
  - If yes select option and give details: | Similar treatment | Similar circumstances |
  - Details of similar treatment or circumstances:
### Advance decision type
- **Written**
- **Verbal**

<table>
<thead>
<tr>
<th><strong>Advance decision type</strong></th>
<th><strong>Written</strong></th>
<th><strong>Verbal</strong></th>
<th><strong>Date of advance decision</strong></th>
</tr>
</thead>
</table>

### What was the decision? (Give details. If advance decision was verbal, detail to whom, in what circumstances)

**Details:**

### Is this decision still applicable?
- **Yes**
- **No**

**If ‘No’ select option below and give reasons (check guidance)**
- **Withdrawn**
- **Unanticipated circumstances**
- **LPA/EPA granted regarding decision**
- **Inconsistent behaviour**
- **Detained under Mental Health Act 1983**
- **Other**

**Details:**

### Determination of best interest *(Note any documentation referenced)*

**IMCA required?**
- **No**
- **Yes**

**Name**

**Tel. No.**

### What is most important to the person as regards this decision? *(Current and past views, e.g. written statement)*

**Details:**

### Views of interested others *(E.g. family, friends, carers, LPA, IMCA, CPD, etc. Give names and roles. If no-one justify)*

**Details:**

### Views of professionals involved

**Details:**

### Describe any possible conflicts of interest with regard to this decision

**Details:**

### Assessment summary *(Remember any judgment about mental capacity is specific to this decision)*

**Decision requires arbitration?**
- **No**
- **Independent mediation**
- **Court of Protection**

### Considering all the factors what final decision has been reached? *(If arbitration required detail)*

**Details:**

### I confirm that this decision is the least restrictive option or intervention possible. Special considerations for life-sustaining treatment have been considered or are not applicable. This decision has not been biased by age, appearance, condition, gender or race. Every effort has been made to communicate with the person concerned.

<table>
<thead>
<tr>
<th><strong>Decision-maker</strong></th>
<th><strong>Role</strong></th>
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<tr>
<td><strong>Organisation</strong></td>
<td><strong>Telephone no.</strong></td>
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<tr>
<td><strong>Signature</strong></td>
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<tr>
<td><strong>Authorising Manager’s Signature</strong></td>
<td><strong>Electronic</strong></td>
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</tbody>
</table>

**Decision date**

**Authorisation date**
Membership of Policy Development Group

Teresa Candfield  Associate Director Health Partnerships

AfC Consultation Group

Heather Anderson  Health and Therapies Manager (Deputy Head of ISCD)
Caroline Baxter  Head of Integrated Service for Children with a Disability
Geraldine Burgess  Home and Community Support Manager
Jodie Cullen  Community Nurse
Ian Dodds  Director of Standards and Improvement
Mary Head  Deputy Head of Service Emotional Health Service (EHS)
Robert Henderson  Deputy Chief Executive
Caroline Jager  Short Breaks and Aiming High Manager
Simon James  Associate Director SEND
Catherine Johnson  Lead Occupational Therapist (ISCD)
Sandhya Kenyon  Community Paediatrician KHFT
Henry Kilpin  Senior Policy Analyst
Lynn Lock  Young People Substance Misuse Service Manager
Heidi Mansfield  Crofters Manager/Interim Croft Cottage Manager
Suzanne Payne  Head of Strategy and Programmes
Ivana Price  Strategic Head of Integrated Youth Support Services
Candice Raymond  Lead Physiotherapist (ISCD)
Nicola Rocca  Team Leader, Disabled Children’s Nursing Team
Clive Seall  Interim Strategic Head of Family Support Services
Jo Steer  Head of Service Emotional Health Service (EHS)
Alison Twynam  Director of Social Care

Peer reviewers
Heather Anderson
Jo Steer