Tameside Adult Safeguarding Partnership Board

Multi-Agency Mental Capacity Act & Deprivation of Liberty safeguards Policy and procedure for staff

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1. Introduction

1.1 The Mental Capacity Act (MCA) 2005 provides a statutory framework to empower and protect vulnerable people from the **age of 16** who may not be able to make their own decisions. It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

1.2 The Act enshrines in statute current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It provides for reform and updating of the current statutory schemes for enduring powers of attorney and Court of Protection receivers.

1.3 Tameside complies with the statutory provisions of the Mental Capacity Act (http://www.legislation.gov.uk/ukpga/2005/9/contents)

- The Independent Mental Capacity Advocate service (IMCAs) can be arranged by a social worker/Learning Disability Nurse or community mental health nurse.
- The Act provides for the criminal offence of ill treatment or wilful neglect of persons who lack capacity by their carers, deputies or power of attorneys
- Sections 1-4 of the Act (the principles, assessing capacity and determining best interests) which are essential to how IMCAs operate and where it is appropriate for an IMCA to be involved.
- There is a Code of Practice for the Act:

http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legal-policy/mentalcapacity/mca-cp.pdf

- Staff involved in statutory best interests decisions whether IMCAs have been instructed or not, will be required to have regard to the Code.
  - Staff are required to have regard to the Code for all purposes (beyond IMCAs in England and Wales).

2. Purpose

2.1 The purpose of this policy is to inform health and social care staff about the arrangements for working with service users over the age of 16 with impaired mental capacity to make decisions.

2.2 It will set out the procedures for staff to follow in assessing capacity and making best interests decisions.

2.3 We have always had a key role in helping and supporting people with impaired mental functioning to understand what decisions need to be made and why, and what the consequences of those decisions are. We are sometimes the only people in a position to provide information to service users about the options available to them, or where they can get other help and or advice. This guidance should increase staff awareness of the different options available to people to help them in these situations.

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2.4 We also need to be able to determine a person's mental capacity in relation to the decisions they face both throughout the social care process and more widely in their lives. In the past, Health, Adults and Children's Social Care Staff have had to rely on common law guidance alone when arriving at decisions. The Mental Capacity Act 2005 provides a framework for the protection of service users with cognitive impairments that affect their decision making and helps staff understand how to act in their best interests.

2.5 This policy aims to guide staff to work within the statutory framework.

2.6 **This is an interim policy and will be revisited following the publication and implementation of the new Mental Capacity Act/Liberty Protection Safeguards Code of Practice and Regulations**.

3. Scope

3.1 Staff who are involved in providing care, support or treatment to any person who lacks capacity to make any decision are required to follow the Mental Capacity Act 2005 and its corresponding Code of Practice.

3.2 This document will set out the policy context and procedures for multi-agency professionals to follow.

4. Learning from Adult safeguarding Reviews

4.1 The focus on mental capacity assessments and the need to review the previous Policy and Procedures is in response to learning and recommendations identified in 13 Safeguarding Adult Reviews (SARs) completed in 2019 and 2020 by the joint Tameside Children's and Adults' Safeguarding Partnership Boards .

4.2 SAR learning highlighted the following:

- Lack of confidence to undertake mental capacity assessments
- Inconsistent approach to conducting mental capacity assessments
- Limited evidence that the principles of the MCA 2005 had been applied
- Consent (and power of attorney) not consistently considered in assessments
- Lack of understanding and recording of Best Interests Decisions
- Failure to meet individuals' human rights

5. Principles

5.1 The MCA (Mental Capacity Act 2005) has five principles, which underpin its fundamental concepts and govern its implementation.

5.2 The five key principles are:

- *Assume capacity unless it is proved otherwise* – every person governed by the 2005 Act has the right to make his or her own decisions and must be assumed to have capacity to do so unless proven otherwise
- *Give all appropriate help before concluding someone cannot make their own decisions* – everyone should be encouraged and enabled to make their own decisions, or to participate as fully as possible in decision-making, by being given the help and support they need to make and express a choice

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- *Accept people's right to make what might be seen as eccentric or unwise decisions*
- *Always act in the best interests of people without capacity* - decisions made on behalf of people without capacity should be made in their best interests, giving weight to the decision being what they themselves would have wanted; and
- *Decisions made should be the least restrictive of their basic rights and freedoms*.

6. Roles and Responsibilities of Staff Working with the Mental Capacity Act

6.1 Health and Social Care Staff

6.1.1 The Mental Capacity Act 2005 identifies the need for all practitioners to carry out decision and time specific assessments of mental capacity where there are doubts about a person's ability to make the relevant decision. The kinds of decisions which are covered by the MCA 2005 range from day-to-day decisions to significant decisions. It is important to note that Mental Capacity Act 2005 training should be mandatory for all staff and that employers are responsible for providing it.

6.1.2 More serious decisions have greater consequences for the person who is thought to lack capacity, and justify a more formal assessment of capacity. The latter includes decisions relating to providing healthcare or treatment, providing nursing and social care, major financial decisions, carrying out diagnostic examinations and tests, providing professional medical treatment, giving medication, providing emergency care, carrying out other necessary medical procedures and therapies and arranging to refer someone to hospital for an assessment or for treatment.

6.1.3 Some decisions can never be made in a person's Best Interests e.g. marriage, divorce, voting, sexual relationships.

6.2 Ambulance Service

6.2.1 North West Ambulance Service NHS Trust (NWAS) provides ambulance services to the North West of England including Greater Manchester.

6.2.2 There are two significant MCA 2005 interfaces with NWAS:

- *Acting in the Best Interests of a patient who lacks mental capacity* - Clinicians should use the two stage MCA test of capacity to make an assessment of the person's mental capacity and a Best Interests decision should be made if they are found to lack capacity to make the relevant decision. If a decision is made to convey in the persons' Best Interests, clinicians should try to persuade the patient to cooperate with them. If the patient is resisting transfer to a local hospital, clinicians can use necessary and proportionate restraint (sections 5 and 6 MCA 2005). If the patient continues to actively resist and there is a significant risk of injury to either the patient or Clinicians, they can request the assistance of Greater Manchester Police. In both instances the form 'Conveyance of Patient Lacking Capacity to Hospital/Care Home' (MCA18), should be completed. If a decision is made not to convey the decision should be appropriately documented. Clinicians should also consider whether a 'Vulnerable Adults' referral is indicated in this incidence.

- *Acting with respect to an Advance Decision that has been made by a patient* - The ambulance service has the capacity to 'flag' specific instructions, as a 'clinical alert' to a patients' address which will be relayed to crews responding to an emergency call. Best Interests 'allow a natural death' (Do Not Attempt Cardio-Pulmonary Resuscitation) decisions are generated by healthcare professionals rather than patients but must also be signed by the patient's GP or appropriate doctor. All advance care documents must also be retained within the client's home and be easily accessible in an emergency.

- Health and social care staff should inform the NWAS Medical Director of Advance Decisions to allow a natural death in order that a clinical alert can be instigated.

6.3 Police

6.3.1 Although the Mental Capacity Act 2005 is primarily aimed at health and social care professionals and carers when making decisions about a person's welfare, it will also be applicable to police officers attending to individuals who appear to lack capacity to make relevant decisions in the circumstances. Often a person who is reasonably believed to lack capacity to make the relevant decision is in need of urgent medical treatment. In these cases officers will usually need to make immediate decisions while awaiting further assessment by a health or social care professional. The Act will cover instances of temporary incapacity for example due to injury/concussion following a head injury, substance misuse or mental ill health.

6.3.2 It should be noted that the Mental Capacity Act 2005 cannot be used to remove apparently mentally disordered persons to a place of safety for the purposes set out in sections 135 and 136 of the Mental Health Act 1983. See *R (Sessay) v (1) South London and Maudsley NHS Foundation Trust and (2) Commissioner of Police of the Metropolis [2012] 2 WLR 1071*

6.3.3 Sections 5 and 6 of the Mental Capacity Act 2005 provide protection from liability in civil and/or criminal proceedings for necessary acts done in the Best Interests of a person lacking capacity. This protection only applies where the officers have taken the steps set out in those sections. The MCA Code of Practice at paragraph 6.5 sets out various actions that might be covered by s.5, which include taking someone to hospital for assessment or treatment and providing care in an emergency.

6.3.5 Where restraint is carried out, officers must reasonably believe it is necessary to prevent harm to the person and the restraint must be a proportionate response to the likelihood of harm and the seriousness of that harm (s.6 (2) and (3)). Restraint as defined in that section refers to where force is applied or threatened to ensure the action which the person resists is carried out or where there is restriction of the person's liberty of movement whether or not s/he resists.

6.3.6 If officers encounter a person who they reasonably believe to lack capacity in relation to the specific decision, they should consider taking action to safeguard the person's Best Interests, having regard to how that purpose can be achieved in a way that places the least restrictions on the person's rights and freedom of action. Some people will experience fluctuating capacity which can affect their ability to understand information and make decisions within a period of time.

6.3.7 Where police are the only service on the scene, it may be necessary to make an assessment of capacity and act accordingly before other services arrive due to the seriousness or urgency of the situation. If the Mental Capacity Act 2005 is used, officers should ensure they record the steps they took to establish the person lacked capacity. When a doctor, member of the ambulance service or other professional arrives on the scene, police should defer to their expertise and provide support as appropriate.

6.3.8 Although it is not possible to be prescriptive in advance, because each case has to be assessed on its merits, officers must inform themselves of where the MCA 2005 likely applies and where it is clear they are not called upon to use their powers of arrest under PACE. See *ZH v Commissioner of Police for the Metropolis (2013) EWHC* provides an example of this).

6.3.9 The police may prosecute a carer for a person who lacks capacity, their Lasting/Enduring Power of Attorney or court appointed Deputy if they ill-treat or wilfully neglect the person lacking capacity under Section 44 of the Mental Capacity Act 2005.

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6.4 Voluntary & Non-Voluntary Sector Providers

6.4.1 It is expected that all partners and voluntary sector providers develop their own organisational Mental Capacity Act 2005 operational procedures to apply when concern about a person's decision making capacity arises.

All Providers should have their own individual procedures & policies which should reflect upon the multi-agency policy. Providers should also ensure that their staff have appropriate training.

6.4.2 If concerns are identified, providers are advised to discuss this with the person and their family and explain the process of assessment and best interests decisions, the role of an Independent Mental Capacity Advocate or of the Court of Protection if appropriate.

7. Assessing Capacity

7.1 The Test of Capacity

The MCA sets out a single clear test for assessing whether a person lacks '*capacity to take a particular decision at a particular time'*. It is a '*decision-specific'* test. No one can simply be labelled 'incapable' as a result of a particular medical condition or diagnosis. Reference should be made to chapter 4 of the code of practice, which looks at how the Act defines a person's capacity to make a decision and how capacity should be assessed (although this is due to be amended to bring it in line with the caselaw)

7.2 Defining a Lack of Capacity

7.2.1 The law gives a specific definition of what it means to lack capacity for the purposes of the MCA 2005. It is a legal test, and not a medical test as described in s.2(1) MCA 2005: '*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or the brain'*.

7.2.2 It does not matter whether the impairment or disturbance is permanent or temporary.

7.2.3 A lack of capacity cannot be established merely by reference to:

- a person's age or appearance, or
- a condition or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.

7.2.4 Any question whether a person lacks capacity must be decided on the balance of probabilities and the 'burden of proof' is for the professional undertaking the assessment to identify that a person has or has not got capacity regarding specific decision making.

7.2.5 To apply the capacity test, it can be broken down into three questions:

- Is the person able to make a decision? If they cannot:
- Is there an impairment or disturbance in the functioning of the person's mind or brain? If so,
- Is the person's inability to make the decision because of the identified impairment or disturbance?

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The ordering of the first and second questions are opposite to what is set out in the Code of Practice at present but this is the order laid down by the Supreme Court in *A Local Authority v JB* [2021] UKSC 52 at paragraph 79. Therefore this order is recommended practice.

7.3 Ability to Make Decisions (The Functional Test)

7.3.1 Section 3(1) states that P is unable to make a decision for himself if he is unable:
• to understand the information relevant to the decision; or
• to retain that information; or
• to use or weigh that information as part of the process of making the decision; or
• to communicate his decision (whether by talking, using sign language or any other means).

1. Understand information relevant to the decision
    - The person must be able to understand the nature of the decision and the consequences. The understanding doesn't need to be in depth, a broad understanding is acceptable under the MCA 2005.
    - The information should include possible options, and what happens if the decision is not made.
    - All possible help must be given to the person to understand the information, including using simple language and visual aids if needed.
    - The assessor should undertake the assessment in the best environment for the person and at the best time of day for them.

2. Retain that information
    - The information only needs to be retained for long enough to make the decision in question. There is no set time limit for how long this is.
    - The person only needs to have capacity at the time the decision needs to be made. It might be necessary to repeat the discussion again at another time before the action is taken to demonstrate that the person's decision is the same.
    - It is important to help the person retain the information, use of notes, or recording the decision are steps that could be taken.

3. Use or weigh that information as part of the process of making the decision
    - The person should be able to demonstrate that they understand the consequences of the decision.
    - This might mean giving them time to think about it, and to weigh the advantages and disadvantages.
    - It might be necessary to involve another person to help in the weighing up process, such as an advocate, carer, friend, or family member.

4. Communicate their decision (whether by talking, using sign language or any other means)
    - The assessor should ensure that the person's capacity is not misjudged because they have difficulty understanding them.

7.3.2 Assessors are required to have due consideration to other parties involved in an individual's life and decision making and best practice denotes that parents, carers, providers should be consulted as to their knowledge of an individual's known wishes. This is to ensure that the individuals stated wishes prior to incapacity are recorded.

7.3.3 Capacity should be presumed unless there is clear evidence to the contrary.

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7.4 Factors Which May Affect Capacity

7.4.1 A person's mental capacity can vary or be temporarily impaired due to mood or depression and drug or alcohol intoxication. Alcohol Change UK – How to use legal powers to safeguard highly vulnerable dependant drinkers in England and Wales. In these circumstances, it may be possible to put off a decision until such time as the person has regained capacity.

7.4.2 A person's mental capacity may also vary or be temporarily impaired due to an underlying physical disorder, known as delirium or *'acute confusional state'* which is a common clinical syndrome characterised by disturbed consciousness, cognitive function, or perception, which has an acute onset and fluctuating course. It usually develops over 1–2 days.

7.4.3 A person may have the capacity to make some decisions but not others. We must weigh up a person's capacity against the specific decision that needs to be made. For example, a person who cannot understand the financial issues around entering long term care might still have the capacity to make a choice about whether they want to go into long term care at all and, if so, which home.

7.4.4 *Information* - Make sure that any information relevant to the decision is provided in a format that the person can understand.

7.4.5 *Pressure/Coercion* - Carers or family members may sometimes exert undue pressure on the person, when actually the person is capable of making their own decisions or where expert help maybe required to help them do so. The Domestic Abuse Act 2021 introduced a statutory definition of Domestic Abuse which also includes emotional abuse, coercive and controlling behaviour and economic abuse.
https://www.lawsociety.org.uk/topics/family-and-children/domestic-abuse-act-2021

7.4.6 *Disguised compliance* - Involves **parents, carers and users of services giving the appearance of co-operating or being pleasant with professionals to avoid raising suspicions and allay concerns**.

In adults it could be a sign of a cognitive impairment or issues with their executive functioning or other illness (delirium caused by urinary tract infection) that may affect their capacity to carry out certain tasks. However, they want to hide this from professionals and their family, as they don't want to show their loss of independence.

It can also be an indication of an individual experiencing domestic abuse, not being taken to planned health and social care appointments, not taking, and not ordering of medication prescribed by the GP. Finances may also be a factor when paying for care services, they may seem disorganised with finances or unable to pay when they are on the relevant benefits.

Using your professional curiosity and asking those additional questions may support you in your practice. We may also have to ask difficult questions or gently challenge a person to achieve the best outcome for the individual.

7.4.7 *Trust* - A person may feel anxious about dealing with staff from Adult or Children's Social Care or any other interested agency, so ensure that the person has access to independent support, advice or advocacy in these circumstances.

7.4.8 Factors which professionals may find more complex when assessing capacity include:

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Fluctuating capacity – this may occur due to the nature of the condition they have. In these circumstances it is important assess over a period of time (at different times of the day) and to consider whether the decision to be made is 'one off' or 'repeated decisions'. A person presenting with fluctuating capacity will need regular reviews of their decision-making ability.

Executive functioning/capacity – a person may give superficially coherent answers to questions but are unable to follow through the actions (they can 'talk the talk, but not walk the walk'). Is the person able to use/weigh the information given? Are they able to identify the possible risks and understand the consequences of their behaviour?

Refusal to participate in the capacity assessment – a person may decline to take part in a capacity assessment. It is important to understand if they are *unwilling* or *unable* to take part. Has the person been involved in discussions about why the assessment is being undertaken? What has been done to engage the person? Are there other people who could support? Is there any coercive or controlling behaviour on the part of a third party? If the risks are high then an application to court may be needed to decide whether the person has or lacks capacity to make the relevant decision.

8. Best Interests

8.1 The MCA 2005 provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests (chapter 5, MCA 2005
). The person's current wishes and feelings should be taken into consideration as well as any known previous wishes and feelings. Also, carers and family members have a right to be consulted.

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 circumstances
- 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 (e.g. religious, cultural, moral, or political) that would be likely to influence the decision in question.
- any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

Avoid discrimination

- do not make assumptions about someone's best interests 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 (e.g. after receiving medical treatment).
- if so, can the decision wait until then?

If the decision concerns life-sustaining treatment

- do not be motivated in any way by a desire to bring about the person's death.

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    - you should not make assumptions about the person's quality of life.

Consulting others

- if it is practical and appropriate to do so, consult other people for their views about the person's best interests 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 on similar issues
- anyone engaged in caring for the person, close relatives, friends, or others who take an interest in the person's welfare for example, biological/non-biological family, Next of Kin, Nearest Relative, GP, Social Worker, Nurse, and any other allied health professional (Physiotherapist, Occupational Therapist, Speech and Language Therapist)
- 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. For Best Interests Meeting Guidance, see Appendix 5.

9. Capacity and Covert Medication

9.1
Medicating a person covertly should only be resorted to in exceptional circumstances and, where it is considered to be necessary in accordance with the Mental Capacity Act 2005. Giving someone medication without their knowledge (covertly) is an interference with an individual's right to respect for private life under Article 8 of the ECHR and also an individual's Article 5 right to liberty and security of person. Treatment without consent often amounts to a restriction contributing to the objective factors creating a deprivation of liberty within the meaning of Article 5 of the Convention. Medication without consent and covert medication are elements of continuous supervision and control that can only lawfully be resorted to in an individual's best interests and as the least restrictive option to their rights and freedoms.

9.2 The issue of covert medication is a Best Interests specific decision with significant implications. An example would be someone with a learning disability who lacks capacity to make a decision about treatment for a serious heart condition. The Best Interests decision can be to give the medication in the least restrictive way e.g. mixed with food or drink. For covert medication to be given it would first need to be established that the person concerned lacked capacity to consent to taking the medication and that it was agreed to be in their best interests to proceed covertly by their family and health care professionals.

9.3 Disguising medicine in the absence of informed consent maybe regarded as deceptive. However, a clear distinction should always be made between:

- those patients/clients who have the capacity to refuse medication and whose refusal should be respected
- and those who lack this capacity.

A further distinction should be made between:

- those for whom no disguising is necessary because they are unaware that they are receiving medication
- and others who would be aware if they were not deceived into thinking otherwise.

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9.4 As a general principle, by disguising medication in food or drink, the person is being led to believe that they are not receiving medication, when in fact they are. The staff member will therefore normally need to be guided by what is agreed by a multi-disciplinary group to be in the Best Interests of the patient/client and recorded as such before acting on the decision. Such treatment must be necessary in order to:

- save life or
- prevent deterioration or
- ensure an improvement in the patient's/clients physical or mental health.

9.5 In the circumstances in which covert administration is agreed as the Best Interests plan the following pointers should be taken into account:

- The decision to administer a medication covertly *must not be considered routine* and should only ever be a contingency measure.
- The patient/client must have been assessed for capacity under the Mental Capacity Act 2005 and this should be clearly documented.
- Where incapacity is identified, what is in the patient's Best Interests must be considered.
- Any decision to administer a medication covertly should only be made after full consultation with the multi-professional clinical team (especially the pharmacist), carers, relatives, the relevant person's representative and advocates. If there is no agreement there should be an application to the Court of Protection.
- Review all medication.
- Is the medication still required?
- Is the medication available in an alternative form (e.g. liquid) that would be acceptable? A change of medication will trigger a review.
- Consider palatability, safety and stability of medicines. For stability consider whether the chemical components would be altered should it be crushed or capsule split. Where needed obtain advice from the Pharmacy Department.
- Regular reviews must be undertaken in consultation with the multi-professional clinical team (especially the pharmacist), carers, relatives, the relevant person's representative and advocates. A review date must be discussed and documented when the initial decision to administer medication covertly is made. The frequency of the review should also be documented at this time.
- The rationale, decision and action taken to administer medication covertly must be clearly documented in the person's medical records and include all the names of the parties concerned. This documentation should be easily accessible on viewing any of the person's records within the care/nursing home/community.
- Regular attempts should be made to encourage the person to take their medication, preferably by the team member who has the best rapport with the individual. Equally the person's relative, friend or advocate may be asked to assist with the administration of the medication.
- If a DoLS standard authorisation is to be longer than a period of six months there should be clear provision for regular, possibly monthly reviews of the care and support plan.

9.6 In summary, where there is a Best Interests decision to administer medication covertly, this should occur only in exception cases after consideration of the least restrictive options. The rational for this decision and its review date must be documented. See Guidance for care homes at https://gmmmg.nhs.uk/wp-content/uploads/2021/08/Guidance-for-the-Covert-Administration-ofMedication-FINAL-for-web.pdf

http://www.nice.org.uk/sc1

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10. Taking Photos/Audio/Visual Recording

10.1 Consent

Informed consent should be gained from all people before they are photographed. This should be gained by the person who requests the images. The person should be competent to make the particular decision, received enough information to make it, and not be acting under duress. The requester should explain to the person, and their carers/family members:

- the purpose of the photographs
- where the images will be stored
- how the images will be used

10.2 Mental capacity and consent for photography

Where individuals who appear to lack mental capacity to give informed consent need to have photographs taken, this multi-agency policy and procedures should be followed. This covers issues such as:

- The main principles of the 2005 Act
- Who should assess patients for mental capacity
- The criteria for testing
- Documenting assessments of capacity when examination/recording is required
- The involvement of relatives or Independent Mental Capacity Advocates (IMCA) in communicating with the patient
- Acting in the best interests of the patient.

Family, carers, or an Independent Mental Capacity Advocate (IMCA) may be able to help professionals communicate with a person to establish their wishes. If a person has been assessed as lacking mental capacity to give consent, professionals can still request recording of a patient if it is felt to be in their best interests.

11. Independent Mental Capacity Advocate (IMCA)

11.1 An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for him or her. The IMCA makes representations about the person's wishes, feelings, beliefs, and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

11.2 Arrangements must be made to allow the IMCA to meet the person concerned and see the relevant health, social services and care records. This is to enable the IMCA to perform the function of representing and supporting the person who lacks capacity.

11.3 The Mental Capacity Act 2005 places an obligation on Local Authorities and/or NHS bodies to instruct and consult an IMCA when making decisions for a person who lacks capacity regarding the following areas:
an NHS body is proposing to provide serious medical treatment, or

- an NHS body or local authority is proposing to arrange accommodation (or change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than 8 weeks.

11.4 An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

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- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved
- where disagreements are noted from concerned parties the Local Authority may also instruct an IMCA to engage in a case.

11.5 The current IMCA service is provided by Voicebility. IMCAs:

- Support and represent the person in the decision making process
- Try to work out what the person would choose if they were able to make the decision themselves
- Speak up for a person in talks and meetings where decisions are being made
- Consult with others in the person's life including medical staff
- Look at alternative course of action (least restrictive option)
- Ensure the decision complies with the MCA and it is in the persons best interest
- Prepare a report (decision maker has a legal duty to consider this) • Challenge the decision (including capacity) if necessary

11.6 A referral for an IMCA can only be made by a Health or Social Care professional. The referral process for Voiceability is an online form on the Voiceability website: https://www.voiceability.org/

12. Restraint

12.1 The Mental Capacity Act does not authorise restraint of a person unless two additional conditions are met: (see section 6(4) of the MCA).

- Reasonable belief that restraint is necessary to prevent harm to the person who lacks capacity
- The restraint must be proportionate to the likelihood and seriousness of the harm.

Restraint can also be sanctioned by an order of the Court of Protection under s16 of the MCA 2005.

12.2 Restraint is defined as the use, or threat to use, force to secure the doing of an act which the person resists or restricting the liberty of movement whether or not person resists. In line with the rest of the Act, the restraint must also be in the person's best interests and must be the least restrictive alternative to the person's rights and freedoms.

12.3 Section 6(5) makes it clear that it does not provide any protection for an act depriving a person of his or her liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

12.4 It is important that in circumstances where a person who lacks capacity is refusing or resisting care or treatment that discussions and concerns should be escalated to ensure that appropriate care is delivered. However, where immediate risk is apparent intervention can occur as set out in sections 5 and 6 of the MCA 2005.

12.5 Restraining actions necessary for life sustaining treatment that amount to a deprivation of liberty are sanctioned under section 4B of the MCA 2005.

13. Protections and Safeguards

13.1 Lasting Powers of Attorney (LPA)

13.1.1 The MCA 2005 allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. The MCA 2005 allows people to let an attorney make health and welfare decisions or decisions about their property and financial affairs.

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13.1.2 A Lasting Power of Attorney (LPA) can only be made while the person granting the power is in a position to make their own decisions. If a client lacks capacity to make their own decisions, then they cannot appoint an attorney under a lasting power of attorney. Instead an application for deputyship will have to be made to the Court of Protection.

13.1.3 A LPA for health and welfare can be used only when it has been registered by the Office of the Public Guardian. Conditions of use and restrictions can be placed in the LPA. A health and welfare LPA can only be activated when the donor has lost capacity to deal with their affairs. It can identify which decisions can and cannot be made as well.

13.1.4 The attorneys are not allowed to make decisions that will benefit themselves, and they must always act in the person who lacks capacity's best interests.

13.1.5 A person can be appointed as an attorney if they are over 18, including a relative, a friend, a professional (like a solicitor), or husband, wife, or partner.

13.1.6 A person cannot be appointed as an attorney to deal with finance and property matters if they are under 18, unable to make their own decisions or subject to a debt relief order or currently bankrupt.

13.2 Court Appointed Deputies

13.2.1 The MCA 2005 provides for a system of court appointed deputies. A deputy can only be appointed to act on behalf of a person who no longer has the relevant capacity and had not appointed an attorney before they lost capacity to make the relevant decisions. Deputies can be appointed to make Health and Welfare decisions or decisions about Property and Financial Affairs. A Health and Welfare deputy will not be able to decide to refuse consent to life-sustaining treatment and the court will decide.

13.3 Advance Decisions to Refuse Treatment

13.3.1 Statutory rules with clear safeguards will confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. The decision must be made by a person who is 18 or over at a time when the person has capacity to make it and must specify the treatment that is being refused. The person may withdraw this advance decision at any time by any means except in the case of life-sustaining treatment where the withdrawal must be in writing. (5.4.5 Code of practice).

13.3.2 If there is doubt or dispute about the existence, validity or applicability of an advance decision then the matter should be referred to the Court of Protection for determination.

13.4 Court of Protection and Office of the Public Guardian

13.4.1 The MCA 2005 creates a specialist court and provides for a specialist officer to support the statutory framework for the protection of persons who lack capacity to make decisions for themselves.

- *The Court of Protection* – a specialist Court which has jurisdiction relating to the MCA 2005 and will be the final arbiter for capacity matters. It has its own procedures and nominated judges who can make decisions in the best interests of persons who lack capacity. The court also appoints deputies to make decisions in the best interests of those who lack capacity to do so. For further information and guidance see: http://www.justice.gov.uk/courts/rcj-rolls-building/court-ofprotection

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The Office of the Public Guardian is created for the purpose of the MCA 2005. The Public Guardian and his/her staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his/her functions. See http://www.justice.gov.uk/about/opg

13.5 Endurance of existing Enduring Powers of Attorney

13.5.1 All care staff should be aware that existing Enduring Powers of Attorney (EPAs) continued following implementation of the MCA 2005 in 2007. EPAs are not automatically replaced by LPAs nor will EPAs need to apply to become LPAs.

13.5.2 All Lasting Powers of Attorney must be registered with the Office of Public Guardian. It will also keep a register of all orders appointing deputies. The office is tasked with maintaining both lists.

14. Ill Treatment and Wilful Neglect

14.1 Section 44 of the Mental Capacity Act 2005 creates the criminal offences of ill-treatment or wilful neglect in relation to carers, attorneys or deputies of people who lack capacity.
The offences can be committed by anyone responsible for that person's care, their attorney or their deputy and are punishable 'either way' in the Magistrates' or Crown Court:

- on summary conviction, to imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both
- on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine or both.

14.2 The elements to be considered about the alleged offender are that the alleged offender:

- is the carer of the person in question OR is their attorney under a Lasting/Enduring Power OR is a court-appointed deputy;
- reasonably believes the person lacks capacity (or they do lack capacity);
- they ill-treat or wilfully neglect the person.

14.3 It can be expected that ill-treatment will require more than trivial ill-treatment and will cover both deliberate acts of ill-treatment and also those acts which could be considered to be reckless.

14.4 Wilful neglect will require a serious departure from the required standards of treatment and usually shows that a person has deliberately failed to carry out an act that they were aware they were under a duty to perform. In consequence, defences could be raised to the effect that the elements of the offence set out in Section 44 are not made out in the following terms:

- there is no Section 44 relationship (not carer/attorney/court-appointed role)
- the person does not lack capacity and/or there was no reasonable belief in such a lack of capacity
- there was no ill-treatment or wilful neglect.

15. Deprivation of Liberty Safeguards

15.1 The MCA 2005 provides a statutory framework for acting and making decisions on behalf of those who lack the capacity to make those decisions for themselves who are aged 16 and older. Within the Act is Schedule A1 which sets out the Deprivation of Liberty Safeguards (DoLS) which aim to prevent the unlawful detention of people who

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have reached 18 and are being cared for in hospitals and care settings and also who lack capacity to choose where they live and/or to consent to care and treatment.

15.3 With regard to people receiving care in their own homes in the community, the Supreme Court in *Cheshire West* determined that if a person lacks capacity to consent to the care and/or treatment arrangements, is not free to leave and is subject to continuous supervision and control, they are deprived of their liberty. Justice Hale describes the two latter elements as the 'acid test'. She also concluded that it is irrelevant whether or not the person objects to the arrangements for their care or whether or not the arrangements are considered to be in the person's best interests.

15.4 The MCA 2005 sets out how arrangements that amount to deprivation of a person's liberty can be regularised under the law in differing settings as follows:

- Registered Care Homes - authorisation via Deprivation of Liberty Safeguards.
- Supported Living/domestic settings such as adult family placements - authorisation via the Court of Protection (you will need to obtain specific legal advice regarding the steps you need to take in these circumstances).
- Mental Health Wards/Hospitals - authorisation via the Mental Health Act 1983 on Psychiatric wards or application for DoLS.
- Acute Hospitals – authorisation via Deprivation of Liberty Safeguards.

15.5 Anyone can request a deprivation of liberty assessment but in general it will be the role of the Managing Authority (care home or hospital) to alert the Supervisory Body (relevant local authority) of care arrangements that deprive of liberty and to seek authorisation. The local authority then commission assessments by a Best Interests Assessor and mental health assessments by a medical practitioner approved under s12 of the Mental Health Act 1983.

15.6 Everyone on a DoLS authorisation will have a representative, either a family member or a friend OR a paid representative if no family/friends are identified to take on this role.

15.7 Independent Mental Capacity Advocates (IMCAs) will represent a person being assessed by a Best Interests Assessor if they have no friends or family to represent them. An Independent Mental Capacity Advocate will also be available to provide support to family or friends acting as representatives (See Section 7 in the document on IMCAs).

15.8 A deprivation of liberty can occur in community and domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement. Where there is, or is likely to be, a deprivation of liberty in such settings, this should be authorised by the Court of Protection.

16. How Does the Act Apply to Children and Young People?

16.1 For further guidance we recommend staff refer to Chapter 12 in the Mental Capacity Act Code of Practice.

16.2 The MCA applies to young people 16+ with capacity issues and it can also apply to under 16's in the following circumstances:

- where the child has an impairment of mind or brain and lacks capacity currently and is likely to still lack it for financial purposes at 18 years (section 2.6 of the MCA)

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  - Offences of ill treatment or wilful neglect of a person without capacity can also apply to victims younger than 16 (section 44 of the MCA).

- 16.3 The Mental Capacity Act 2005 applies to people aged 16 and over with the exception that young people aged 16-17 years, who may lack capacity within section 2(1) to make specific decisions. There are three exceptions:
- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over.

17. Deprivation of Liberty (Young People)

17.1 A 'young person' in the context on the Mental Capacity Act 2005 refers to a 16- or 17-year-old. The relevance of Article 5 ECHR to young persons who *lack capacity* to decide where to reside in order to receive care and treatment is the focus of this section.

17.2 DoLS relating to adults is very different to Deprivation of Liberty applied to young people. DoLS for adults refers to the *process* of applying and authorising safeguards for people who are deprived of their liberty in care settings and hospitals. The principle of Deprivation of Liberty and young people relates predominantly to those 16 or 17 year olds who *lack capacity* and are placed in foster homes, children's homes and residential special schools, have liberty restricting measures put in place and meet the criteria for the nuanced 'acid test' (the young person is under the complete supervision and control of those caring for them and is not free to leave the place where they live). Neither DoLS nor the Mental Health Act 1983 are available to authorise deprivations of liberty here, so judicial authorisation will be required. The Court of Protection can authorise the deprivation of liberty of young persons lacking the relevant mental capacity (i.e. 16 and 17 year olds). The inherent jurisdiction of the High Court is available to younger children who lack capacity to make decisions about care arrangements depriving them on liberty.

17.3 If a young person is deprived of their liberty, the consent of those with parental responsibility cannot be relied upon to authorise it as the decision falls outside the scope of parental responsibility. This would apply as equally to local authorities sharing parental responsibility under a care order as it does to parents.

17.4 Examples of liberty restricting measures include:

- Decision on where to reside being taken by others
- Decision on contact with others not being taken by the individual
- Restrictions on developing sexual relations
- Doors of the property locked and/or bolted for security reasons or to prevent the young person from leaving
- A member or members of staff accompanying the person to access community support and meet their care needs
- Access to the community being limited by staff availability
- Mechanical restraint, such as wheelchairs with a lap strap or specialist harness
- Varying levels of staffing and frequency of observation by staff
- Provision of 'safe places' or 'chill out' rooms or spaces during the day or night from which the person cannot leave of their own free will
- Restricted access to personal allowances
- Searching of the person and/or their belongings
- Restricted access to personal belongings to prevent harm
- Medication with a sedative or tranquilising effect

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  - Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds (e.g. 'Team Teach' methods)
  - Restricted access to modes of social communication, such as internet, landline or mobile telephone or correspondence
  - Positive behavioural reward systems to reward 'good' behaviour
  - Disciplinary penalties for poor behaviour
  - Restricting excessive pursuance of activities
  - Lack of flexibility, in terms of having timetabled, set mealtimes, expected sleep times
  - Managing food intake and access to it
  - Police called to return the person if they go missing
  - Restricted access to parts of the property, such as the kitchen or certain cupboards therein to minimise health and safety risks.

17.5 If you are supporting a young person who is 16 or 17 years old who you have assessed as lacking capacity to make decisions about their care and treatment and you believe they are being deprived of their liberty, discuss the case with your manager as further legal advice will be needed.

17.6 For further information go to:

- http://www.communitycare.co.uk/2016/03/01/deprivation-liberty-young-people-social-workersneed-know/
- https://www.lawsociety.org.uk/Support-services/documents/Deprivation-of-liberty---a-practicalguide/ (chapter 9 – under 18s).

18. Excluded Decisions

18.1 The MCA 2005 sections 27-29 lists certain decisions that can never be made on behalf of a person who lacks capacity. They are as follows (Extract from MCA 2005 sections 27, 28 & 29)

18.2 *Section 27 Family relationships etc.*

(1) Nothing in this Act permits a decision on any of the following matters to be made on behalf of a person -

(a) consenting to marriage or a civil partnership,

(b) consenting to have sexual relations,

(c) consenting to a decree of divorce on the basis of two years' separation,

(d) consenting to the dissolution order being made in relation to a civil partnership on the basis of two years' separation,

(e) consenting to a child's being placed for adoption by an adoption agency,

(f) consenting to the making of an adoption order,

(g) discharging parental responsibilities in matters not relating to the child's property

(h) giving consent under the Human Fertilisation and Embryology Act 1990(c.37)

(2) "Adoption order" means –

(a) an adoption order within the meaning of the Adoption and Children Act 2002 (c. 38) (including a future adoption order), and

(b) an order under section 84 of that Act (parental responsibility prior to adoption abroad).

18.3 *Section 28 Mental Health Act matters*

(1) Nothing in this Act authorises anyone –

(a) To give a patient medical treatment for mental disorder, or

(b) To consent to a patient being given treatment for mental disorder,

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If, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act 1983.

(2) "Medical treatment," "mental disorder" and "patient" have the same meaning as in that Act.

18.4 *Section 29 Voting rights*

(1) Nothing in this Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person.

(2) "Referendum" has the same meaning as in section 101 of the Political Parties, Elections and Referendums Act 2000 (c. 41).

18.5 *Section 62 Unlawful killing or assisting suicide*

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

19. Payment for Goods and Services

19.1 Staff should be aware that previous legislation and common law rules have now been brought together by the MCA 2005 regarding a person lacking capacity and the purchase of 'necessaries' in terms of goods and services.

19.2 The MCA makes it clear that a person lacking capacity must pay a 'reasonable price' for goods and services supplied to them. A person who is acting under section 5 MCA 2005 may arrange something for a person's care or treatment and promise that the person receiving the care and/or treatment will pay for it. This is restating the common law rules which provide that a person acting as an 'agent of necessity' should not be out of pocket for acting in good faith.

19.3 The MCA 2005 does not provide for a person acting for an individual lacking capacity to access that individual's bank or building society account. Formal steps may be taken to arrange this i.e. registering a power of attorney or obtaining a court order or being appointed their benefits appointee by the Department for Works and Pensions..

19.4 Where a contract for tenancy or other services is required the appropriate legal authority to act must be held for finance and property matters.

19.5 Spending decisions should be supported by "best interest decisions" wherever possible and it is good practice to obtain three estimates for purchase of goods or services to support the principles of Best Value.

19.6 Section 28 of the MCA 2005 ensures that the Act does not apply to any treatment for a medical disorder which is being given in accordance with the rules about compulsory treatment as set out in Part IV of the Mental Health Act 1983. Staff should be aware that the statutory safeguards which the Mental Health Act 1983 gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom the Mental Health Act 1983 applies.

20. Research

20.1 The Act lays down clear parameters for research where people without capacity maybe the subjects. The Act provides detailed rules on the requirements and procedures to be followed for intrusive research involving people who lack capacity. Intrusive research is defined as any research that requires a person's consent.

20.2 To carry out intrusive research on a person who lacks capacity to consent the following criteria must be met:
It has been approved by an appropriate body *and*
Consultation with carers and others has taken place *and*
Additional safeguards are followed.

20.3 An appropriate body is defined as a person, committee or other body as specified in the regulations by the Secretary of State for Health, for example a Research Ethics Committee.

120.4 The research project must take reasonable steps to identify and consult with someone involved in the care and welfare of the person, other than someone working in a professional capacity or in return for payment.

120.5 If a person who lacks capacity is taking part in research, then a range of safeguards apply, e.g. nothing is done that is contrary to an Advance Decision. All the normal decision-maker's guidelines and other Code of Practice principles also apply to making decisions about taking part in research. For more detail see Chapter 11 of the MCA Code of Practice.

21. Procedure

The following procedures apply to all staff as defined in the above scope who are working with adults who may lack the capacity to consent to their care or treatment, including in circumstances that might be considered a deprivation of liberty.

Assessing Mental Capacity

- Firstly, adhere to MCA Policy key five principles
- ○ *Assume capacity unless it is proved otherwise*
    - *Give all appropriate help before concluding someone cannot make their own decisions ○ Accept the right to make what might be seen as eccentric or unwise decisions ○ Always act in the best interests of people without capacity*
    - *Decisions made should be the least restrictive of their basic rights and freedoms*

When to Assess Capacity?

- The person is unable to make a specific decision
- You suspect a person has an "impairment" or disturbance of mind/brain that is affecting their ability to make the decision under consideration
- At the time the decision needs to be made
- If there is more than one decision to be made, then a capacity assessment should be done for each decision

Who Should Assess Capacity?

- The person directly concerned with the individual at the time – the Code of Practice is not prescriptive
- For more complex situations it may be another professional depending on the situation
- For example, if it is a 'clinical' decision about medical treatment, a doctor/consultant/nurse should assess. If it is a decision to go into a care home, a social worker would be best placed. If it is a legal decision (sign a Will or LPA) a solicitor should assess
- Assess capacity

If the Person Has Capacity?

- Person must be able to make decision for themselves

If the Person is Lacking Capacity – Best Interests Decision Making

- Complete Best Interests Assessment
- Consider relevant party's best interests consultation
- Does the person require representation from an IMCA?
- Implement best interest decision.

Decision Makers for Best Interests?

- The MCA allows Lasting Powers of Attorneys or Court deputies to be granted if required
- The statutory best interest checklist should be considered
- The decision maker may consider the need for an IMCA
- Do you need to consider the decision at a later date?
- Meeting or discussion?

- Best Interests guidance
- In very complex cases you may need to discuss with line manager and/or legal team.

Where and how is the Assessment Recorded?

Capacity assessments must be *criteria-focussed, evidence based, person-centred and non-judgmental.* Professionals need to engage with the person to understand who they are, free of pre-judgment and stereotype.

The Mental Capacity Assessment/Best Interests Decision form is to be completed or written in the person's records (refer to your own agencies recording forms).

The Important Factors to Consider when Recording:

- Be clear about the capacity decision that is being assessed
- Ensure the person (and you) have the concrete details of the choices available (e.g. for example between living in a care home and living at home with a realistic package of care)
- Identify the salient and relevant details the person needs to understand/comprehend (ignoring the peripheral and minor details)
- Demonstrate the efforts taken to promote the person's ability to decide and record this
- Assessment is not necessarily a one-off matter, record that you have taken the time to gather as much evidence as is required to reach your conclusion – including, for instance, returning to have a further conversation with the person or obtaining corroborative evidence
- Verbatim notes of questions and answers can be particularly valuable in the record of the assessment
- Do not assert an opinion unless it is supported by a fact
- You must also be prepared to justify a decision not to carry out an assessment where, on the face of it, there appears to be a proper reason to consider that the person is able to make the specific decision. If the person is deemed to have capacity but the risks are high, and a multi-agency approach is required the Tiered Risk Management and Assessment protocol should be followed https://www.osab.org.uk/cms-data/depot/hipwig/OSAB-TRAM-Protocol.docx
- Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for an individual. This can happen most often in the context of self-neglect where it is unclear whether or not the person has capacity to make decisions

- If you are assessing a person's capacity to make a number of different decisions, it is important to take a step back and ask before reaching a conclusion as to the person's decision-making capacity in relation to each decision
- Evidence each element of your assessment:
    - (i) Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
    - (ii) What is the impairment/disturbance? Is it temporary or permanent?
    - (iii) How is the inability to decide caused by the impairment/disturbance (as opposed to something else)?
    - (iv) Why is this an incapacitated decision as opposed to an unwise one?

Additional guidance is available from 39 Essex Chambers in relation to Carrying Out and Recording Capacity Assessments and Relevant Information for Different Categories of Decision.

22. Information Sharing – Confidentiality and Sharing Information

22.1 Data Protection Act 2018/General Data Protection Regulation 2018

The Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

It allows for the sharing of data where it is necessary in the public interest or for the performance of an official safeguarding function by the organisation in line with Article 6 (1)(e) GDPR and as such consent from the adult is not required. Circumstances include:

- Where one or more partners have reason to believe that an adult is at risk of death or serious injury as a result of actions/inaction by the adult and/or the actions of others.
- The sharing of information is in the public interest and it outweighs the public interest served by protecting confidentiality – for example where serious harm may be prevented.
- Other people are at risk which may include children or other adults with care and support needs.
- An organisation/practitioner feels that there has not been an appropriate response to a safeguarding concern and information sharing is required as part of the escalation process.
- The risk to the adult and or others is considered to be high and meets the criteria for a multi-agency risk assessment under the TRAM Protocol's Complex and High Risk Panel (CaHRP).
- Where a serious crime has been committed.
- Where the person lacks the mental capacity to make the decision – this must be properly explored and recorded in line with the Mental Capacity Act

https://www.osab.org.uk/cms-data/depot/hipwig/OSAB-Data-Sharing-Agreement.pdf

22.2 Third Parties

Sometimes, third parties may request information about someone who lacks capacity. Chapter 16 of the Mental Capacity Act Code of Practice offers general guidance. More specific advice can be obtained from your organisations legal service or from the Information Commissioners at www.ico.gov.uk

22.3 Consent to Share Information

22.3.1 Before any health or social care information can be given, the person receiving care will need to give permission for information to be shared with other professionals or providers. If the person lacks capacity to make this decision the agency, in consultation with any representatives, will need to make a Best Interests decision about sharing information.

22.3.2 Everybody is protected by the Data protection Act 1998/GDPR. This requires organisations to:

- Process personal information fairly and lawfully
- Keep only necessary information
- Use or share if only for stated purposes
- Collect only information that is relevant
- Keep information only for as long as necessary
- Update information as appropriate.

22.3.3 All NHS services and local authorities are protected by a Caldicott Guardian – someone appointed to ensure the organisation handles information correctly. This requires the organisation to justify why they use confidential information, using a minimum of information where necessary, on a need-to-know basis and requires all staff to understand their responsibilities and comply with the law.

23. Resolving Disputes

23.1 There is no formal appeals process under the MCA 2005. The MCA provides open, accessible decision-making and everyone who uses the MCA must be open to challenge. At times this can result in disputes. The decision-maker:

- has the authority to make a decision about someone's capacity and their best interests
- must follow the process to assess capacity
- must follow the Best Interests checklist to decide on someone's best interests – this includes consulting other people such as professionals, family and friends and an Independent Mental Capacity Advocate (IMCA) if appropriate.

If the decision maker follows the correct steps, they have the authority to make the decision. Other professionals may disagree with the decision-maker's conclusion. It would be appropriate to discuss this openly, perhaps in a Best Interests meeting, to try to resolve any dispute. Any dispute as to what is in the best interests of P which is not resolved must be referred to the Court of Protection for it to make the decision.

23.2 Family, friends or an IMCA may disagree with professional decisions, or there may be disputes in someone's circle of family and friends. A best interests meeting may offer a more formal way of involving family or friends in a decision and enable them to accept the decision.

23.3 If the decision-maker represents an organisation providing care, such as the local authority, the NHS or a private provider, they need to demonstrate that the care provided by the organisation is better for the person than anything proposed by their family.

23.4 It may be possible to use mediation to enable people to consider a difficult decision. For advice contact the Family Mediation Helpline or the National Mediation Helpline or other local services.

23.5 If it is not possible to resolve a dispute, the Court of Protection can make a decision. A public authority should seek a Court determination if there is sustained dispute about a decision, although anyone can apply to the Court of Protection. Application to the Court of Protection should be a last resort. In these circumstances get advice from your organisations safeguarding adults and MCA/DoLS leads and the legal department.

24. Making a Complaint

Anyone can make a formal complaint about any services received. People who may lack capacity, or their family or friends, should be offered whatever support they need to make a formal complaint. Follow your organisations complaints procedure.

25. Monitoring and Review

This guidance will be reviewed and updated on an annual basis or where case law directs changes under the MCA.

26. Further Information and Resources

There is a wealth of published advice and guidance on assessment of capacity:

- NICE guidelines www.nice.org.uk/mca-directory/
- Mental Health Law Online www.mentalhealthlawonline.co.uk
- Bournemouth University MCA Toolkit https://mentalcapacitytoolkit.co.uk/
- Alex Ruck Keene https://www.mentalcapacitylawandpolicy.org.uk/
- 39 Essex Chambers https://www.39essex.com/
- BMA Consent Toolkit (2000)
- The joint publication of the BMA and The Law Society “Assessment of Mental Capacity”.
- The website of the Social Care Institute for Excellence provides up to date resources on all aspects of the Mental Capacity Act

http://www.scie.org.uk/publications/mca/

- Code of Practice: Mental Health Act 1983, Department of Health https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- Deprivation of Liberty Safeguards. British Medical Association http://www.bma.org.uk/support-at-work/ethics/mental-capacity/deprivation-of-liberty-safeguards
- Mental Capacity Act 2005 Code of Practice, Office of the Public Guardian (2007) https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- MENCAP ‘Know Your Rights on the Mental Capacity Act’ www.mencap.org.uk
- Office of the Public Guardian https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365631/making_decisions-opg601.pdf
- Mental Health Foundation ‘AMCAT’ site (Assessment of Mental Capacity Audit Tool) http://www.mentalhealth.org.uk/our-work/training/amcat/
- Mental Health Foundation ‘Bridgett’ site (Best Interests decision making)
- Nursing and Midwifery Council https://www.nmc.org.uk/standards/code/
- Mental Capacity Act Manual First Edition (Richard Jones 2005)
- Assessment of Mental Capacity, British Medical Association and The Law Society (4th edition)
- Medical Ethics Today: The BMA’s Handbook of Ethics and Law, British Medical Association (2012)

- Working with the Mental Capacity Act 2005 (2nd Edition). S Richards and A F Mughal

Appendices

Appendix 1 - When to Assess Capacity (Person over 16 years old) Flowchart	Flowchart
Appendix 2 - Best Interest Decisions Flowchart	Flowchart
Appendix 3 - Checklist: Assessment of Capacity	Checklist
Appendix 4 - OSAB Executive Functioning: Mental Capacity Act Guidance	Guidance
Appendix 5 - TSAB Best Interest Meetings Guidance	Guidance