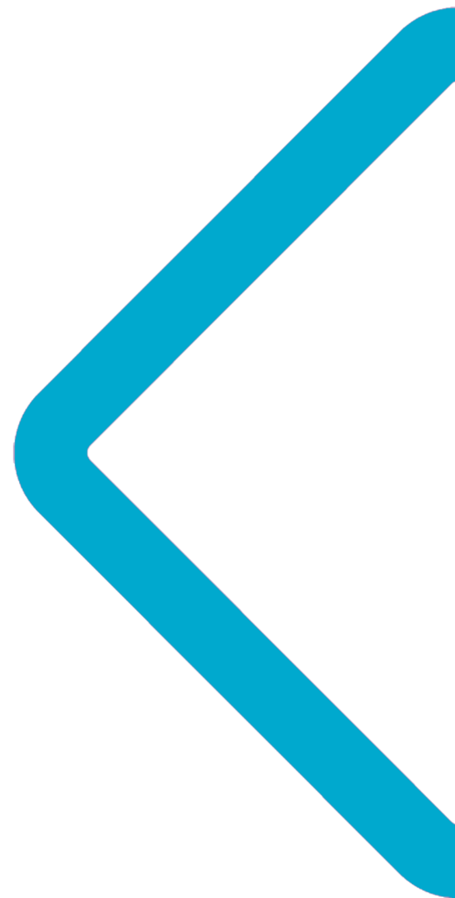
NHS
Cheshire and Merseyside

Mental Capacity Act (2005) Policy

September 2022



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Part 1

1. INTRODUCTION

1.1. The Mental Capacity Act 2005 introduced statutory framework and responsibilities which apply to everyone who is involved in the care, treatment, or support of people aged 16 years and over living in England or Wales, who are unable to make all or some decisions for themselves.

1.2. Everyone working with or caring for people aged 16 years and over, who may lack capacity to make a specific decision must comply with the Mental Capacity Act in full, irrespective of whether the decision relates to a life changing event or an everyday matter.

1.3. This policy sets out how:

a. NHS Cheshire and Merseyside Integrated Care Board will fulfil its duties and responsibilities effectively within its own organisation, including Continuing and Complex Healthcare

b. NHS Cheshire and Merseyside Integrated Care Board will fulfil its Mental Capacity Act duties and responsibilities effectively across the local health economy via its commissioning arrangements

1.4. For the purposes of this policy the Mental Capacity Act 2005 will be called “the Act”.

1.5. The Mental Capacity Act Code of Practice (2007) is a guide on how to apply the Act in practice. Section 42 of the Act requires that those who make decisions in relation to persons who lack capacity must have due regard to the code.

1.6. The duty to have regard to the code applies to those acting in ‘in a professional capacity’ and ‘receiving remuneration’ and consequently will apply to all employees of the Integrated Care Board.

1.7. This policy should be read in conjunction with the:

a. The Mental Capacity Act: Code of Practice
b. Deprivation of Liberty Safeguards (DoLS): Code of Practice
c. NHS Cheshire and Merseyside Safeguarding Children, Adults at Risk and Children in Care policy
d. Cheshire and Merseyside local authorities’ Mental Capacity Act, Deprivation of Liberty Safeguards and Liberty Protection Safeguards policies and procedures

2. PURPOSE AND SCOPE

2.1. The purpose of this policy is to support the Integrated Care Board and its staff in discharging its legal duties under the Mental Capacity Act (2005) and the Mental Capacity (Amendment) Act 2019.

2.2. This requires the Integrated Care Board to understand and be able to apply the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards Codes of Practice.

2.3. This policy aims to ensure that no act or omission by the Integrated Care Board as a commissioning organisation, is in breach of the Act or Deprivation of Liberty Safeguards (2009) and to support staff in fulfilling their legal obligations.

2.4. The Integrated Care Board recognises that the implementation of the Act is a shared responsibility with the need for effective integrated working between those who might lack capacity, other agencies, and practitioners.

2.5. This policy aims to provide direction and guidance to all staff employed by the Integrated Care Board who are involved in the assessment, care, treatment, or support of people over 16 years of age who may lack the capacity to make specific identified decisions.

2.6. Our organisation has a responsibility for commissioning high quality care and treatment and needs to ensure providers understand the Act legal framework and ensure that no act or omission by the services we commission, are in breach of the Act, Deprivation of Liberty Safeguards (2009) or the upcoming Liberty Protection Safeguards.

2.7. The Integrated Care Board Safeguarding Service will monitor provider compliance through the safeguarding standards and Integrated Care Board contract management.

3. DEFINITIONS

Mental Capacity	A person's ability to make a particular decision at a particular time.
Mental Capacity Act 2005 Code of Practice	The Code of Practice provides guidance for people who work with adults who may lack capacity to make decisions. it describes responsibilities when acting for a person who lacks capacity to make a specific decision. All staff should have access to the Code of Practice.

Mental Capacity Act Assessment	A two-stage test underpinned by the first two principles of the act. The test establishes: 1. whether a person can understand, retain, weigh-up or communicate a specific decision. 2. Whether there is an impairment or disturbance of the mind which can be temporary or permanent
Best Interests	if, following a capacity assessment, an individual is found to lack the capacity to make the specific decision, the decision maker should decide what action is in the patient's best interests.
Advance Decision	At a time when a patient has the capacity to make the decision, they may decide that if they lack capacity at some point in the future, they do not want to receive specific treatments. If an Advance Decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed ideally by a carer or relative or if this is not appropriate an advocate or independent third party.
Advance Decision to Refuse Treatment	An Advance Decision to Refuse Treatment
Advance Statement	An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding
Court Appointed Deputy	In certain situations where an individual does not have a Lasting Power of Attorney, but a series of decisions needs to be made the Court of Protection may appoint a deputy who then take on the same functions as an attorney either for a specified period or indefinitely.
Court of Protection	The court that governs the Act including the Deprivation of Liberty Safeguards. It can make decisions regarding a person's mental capacity and what is in their best interests.
Independent Mental Capacity Advocate	An independent advocate for people who lack capacity who can support and represent their views as far as possible.
Lasting Power of Attorney	A Lasting Power of Attorney is a legal document which gives the attorney (or done

	as it sometimes called) the authority to make decisions on the persons behalf. There are two types: Health and Welfare and Property and Financial. To be valid A Lasting Power of Attorney must be registered with the Office of the Public Guardian.
Restraint	Section 6(4) of the Act states that someone is using restraint if they: • use force – or threaten to use force – to make someone do something that they are resisting, or • Restrict a person's freedom of movement, whether they are resisting or not.
Balance of probabilities	The standard of proof used in civil law; an outcome is more likely than not based on the evidence available.

3.1. **Expanded Definition of Mental Capacity**

A person lacks capacity at a certain time if they are unable to decide for themselves in relation to a specific matter, because of impairment, or a disturbance in the functioning of the mind or brain (this could be temporary or permanent). An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

a. A stroke or brain injury
b. A mental health problem
c. Dementia
d. A significant learning disability
e. Confusion, drowsiness or unconsciousness because of an illness or treatment for it
f. A substance misuse

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

3.3. It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore, capacity testing may be required at various periods. Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to assume about their capacity. An assumption that the person is

making an unwise decision must be objective and related to the person's cultural values.

4. ROLES & RESPONSIBILITIES

4.1. The Integrated Care Board is responsible for commissioning high quality health services for people across Cheshire and Merseyside and has a particular duty and commitment to those people who are less able to protect themselves from harm, neglect, or abuse.

4.2. General Roles and Responsibilities of the Cheshire and Merseyside Integrated Care Board

1. Establish clear lines of accountability for implementation of the Act, which is in the governance arrangements.

2. Secure the expertise of a Mental Capacity Act Lead to support policy and training development.

3. Embed the Act into practice, and this is discharged effectively across the health economy through the commissioning arrangements.

4. Ensure that the Integrated Care Board exercises a responsibility in ensuring service users receive treatment within the guidelines of the Acts Code of Practice.

5. Ensure that the Act is identified as a key priority area in all strategic planning processes.

6. Ensure that Acts implementation is integral to clinical governance and audit arrangements.

7. Oversee through governance arrangements that providers comply with the Act, Deprivation of Liberty Safeguards, and the upcoming Liberty Protection Safeguards legislation.

8. Ensure that all health providers commissioned by the Integrated Care Board have comprehensive policies and procedures for the Act including Deprivation of Liberty Safeguards and are easily accessible to staff at all levels.

9. Ensure that all employees of the Integrated Care Board have training in the Act and competency appropriate to their role and responsibilities.

10. Ensure that all contracts for the delivery of health care include clear standards, for implementing the Act; these standards are monitored thereby

providing assurance that the legal framework is being correctly implemented.

11. Ensure that any Integrated Care Board system and process that includes decision making around individual patient activity (e.g., funding panel) clearly demonstrates compliance with the Act. This includes ensuring that assessment of capacity is documented relating to the specific decision and any following decision is documented in line with the best interest process.

12. Ensure the Integrated Care Board is prepared for the Liberty Protection Safeguards implementation.

13. Ensure all health organisations with whom the Integrated Care Board has commissioning arrangements have strategies in place to prepare for the Liberty Protection Safeguards.

4.3. **Chief Executive**

The Chief Executive of the Integrated Care System is the accountable officer has overall responsibility for the strategic direction and operational management, including ensuring that Integrated Care Boards processes comply with all legal, statutory, and good practice guidance requirements.

4.4. The Chief Executive is accountable for ensuring that the health contribution to safeguarding including mental capacity is discharged effectively across the whole local health economy through Integrated Care Board commissioning arrangements.

4.5. This role is supported through the Director of Nursing and Care who holds delegated responsibility and is the Executive Lead for Safeguarding and Children in Care.

4.6. **Director of Nursing and Care**

The Director of Nursing and Care is the delegated executive lead for safeguarding and will take responsibility for governance and organisational focus on safeguarding including mental capacity. They will work closely with the Place Directors, supported by the Associate Directors, Senior Safeguarding Leads and Safeguarding team to ensure the Act legal duties are being delivered.

The Director of Nursing and Care responsibilities are to:

a. Provide strategic leadership for safeguarding and the Act.
b. Ensure the Quality and Performance Committee is appraised of appropriate Mental Capacity Act issues.

c. Ensure that the Act agenda is integral to the Integrated Care Board commissioning functions, governance, and audit arrangements.

e. Ensure that contract specifications include clear service standards for the Act and are monitored through established quality assurance processes within the Integrated Care Board.

4.7. Associate Directors and Senior Safeguarding Leads

The Associate Directors and Senior Safeguarding Leads responsibilities are to:

a. Ensure the Integrated Care Board statutory safeguarding functions are delivered in relation to the Act
b. Provide leadership to the Safeguarding Service
c. Provide expert advice to the Integrated Care Board
d. Provide assurance to the Quality and Performance Committee and Integrated Care Board
e. Ensure the necessary training required to implement this document is identified and resourced.
f. Ensure mechanisms are in place for the regular evaluation of the implementation and effectiveness of this policy.
g. With support from the Designated Nurses/Professionals, ensure the Integrated Care Board has effective Mental Capacity Act systems and processes in place
h. Attend Place Safeguarding Adult Boards, as delegated by the Director of Nursing and Care
i. Attend Place Safeguarding Children's Partnerships, as delegated by the Director of Nursing and Care

4.8. Designated Professional for Safeguarding Adults

The Designated Nurses for Safeguarding Adults responsibilities are to:

a. Provide leadership to ensure that the Act, Deprivation of Liberty Safeguards and upcoming Liberty Protection Safeguards are embedded in the safeguarding agenda across the health economy.
b. Raise the profile of the Act, Deprivation of Liberty Safeguards, and the upcoming Liberty Protection Safeguards to ensure they are understood and effectively implemented in our local health services.
c. Work with the Associate Directors, Senior Safeguarding leads and the Integrated Care Board safeguarding service to ensure robust assurance and oversight arrangements are in place within the Integrated Care Board and provider services.
d. Provide expert advice and expertise to Integrated Care Board staff
e. Provide professional leadership, advice, and support to lead professionals across provider trusts/services and independent contractors.
f. Represent the Integrated Care Board on relevant networks and multiagency groups providing leadership, oversight and implementation of the Act,

Deprivation of Liberty Safeguards, and the upcoming Liberty Protection Safeguards

g. Lead and support the development of related policy, and procedures in the Integrated Care Board in accordance with national, regional, local requirements.
h. Provide advice and guidance in relation to the Act, Deprivation of Liberty Safeguards and Liberty Protection Safeguards training requirements
i. Ensure quality standards for the Act, Deprivation of Liberty Safeguards, and Liberty Protection Safeguards are developed and included in all provider contracts and compliance is evidenced.
j. Work closely with the Designated Professionals for Safeguarding Children and Children in Care to ensure that where appropriate there is effective information flow across both adults and children's safeguarding services in relation to the Act.
k. Attend Place Safeguarding Adult Boards in specialist expert capacity
l. Attend Place Safeguarding Children's Partnerships in specialist expert capacity

4.9. Cheshire and Merseyside Integrated Care Board Staff

All staff, including students, volunteers and agency staff are responsible to:

a. actively co-operate with managers in the application of this policy to enable the Integrated Care Board to discharge its legal obligations of the Act
b. be aware of the groups of individuals who may require assessment under the Act due to an impairment or disturbance of the mind or brain.
c. Document any assessment of capacity or best interest decision made
d. Undertake relevant training and regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the Act.
e. Understand the principles of confidentiality and information sharing in line with the Act.
f. Chair or contribute to single agency or multi-agency best interest meetings when related to funding of placements or care and treatment decisions.

5. MONITORING AND REVIEW

5.1. There are routine reporting arrangements in place for all duties and functions in respect of safeguarding including the Act and Deprivation of Liberty Safeguards in the Integrated Care Board and its commissioned services.

5.2. Assurance will be provided to the Integrated Care Board Safeguarding Oversight Group with Mental Capacity Act compliance concerns escalated from this group into the Integrated Care Board Quality and Performance Committee.

5.3. Method of monitoring compliance of commissioned healthcare providers will be required to complete the NHS England Safeguarding Assurance Framework

(2022) which includes standards for the Act. As part of the monitoring of safeguarding arrangements for commissioned services, safeguarding standards are incorporated into the annual contract process.

5.4. Assurance is provided through the Integrated Care Board safeguarding self-assessment based on the NHS England (2022) Safeguarding Accountability and Assurance Framework. Compliance towards this policy will be achieved by the monitoring of providers using:

a. Safeguarding self-assessment audit tool.
b. Review of serious Incidents
c. Quarterly provider dashboard completion and oversight
d. Monitoring visits

5.5. **Review and Governance**

This document will be reviewed as a result of changes made to multi-agency safeguarding procedures and to reflect any national legislative changes. A review will be undertaken every 2 years or as a result of legislation changes.

The Integrated Care Board Safeguarding Oversight Group will ensure that this policy document is reviewed by the Safeguarding Operational Group in accordance with the timescale specified at the time of approval. No safeguarding policy or procedure will remain operational for a period exceeding three years without a review taking place.

5.6. **Breaches of Policy**

This policy is mandatory. Where it is not possible to comply with the policy or a decision is taken to depart from it, this must be notified to the Integrated Care Board Director of Nursing and Care, so that the level of risk can be assessed, and an action plan can be formulated.

5.7. NHS Cheshire and Merseyside Integrated Care Board Safeguarding Service Contact Details

Place	Generic Safeguarding E-mail Addresses
Cheshire East and Cheshire West and Chester	cheshireccg.safeguardadmin@nhs.net
Halton and Warrington	cmicb-war.halccg.safeguarding@nhs.net
Knowsley	knccg.knowsleydesnurses@nhs.net
Liverpool	safeguardingservice.liverpool@nhs.net
Sefton	Safeguardingservice.sefton@nhs.net
St Helens	sthccg.safeguarding@nhs.net
Wirral	WICCG.Safeguarding@nhs.net

5.8. Cheshire and Merseyside Safeguarding Children Partnerships and Safeguarding Adults Boards Multi-Agency Policies and Procedures links:

Place	Safeguarding Adults Board	Safeguarding Children Partnership
Cheshire East	Cheshire East Safeguarding Adults Board	Cheshire East Safeguarding Children's Partnership (CESCP)
Cheshire West and Chester	Cheshire West and Chester Safeguarding Adults Board	Cheshire West Safeguarding Children Partnership
Halton	Halton Safeguarding Adult Board	Halton Children & Young People Safeguarding Partnership
Knowsley	Knowsley Safeguarding Adults Board	Knowsley Safeguarding Children Partnership
Liverpool	Liverpool Safeguarding Adults Board (LSAB)	Liverpool Safeguarding Children Partnership (LSCP)
Sefton	Sefton Safeguarding Adults Board	Sefton Local Safeguarding Children Partnership
St Helens	St. Helens Safeguarding Adult Board	St. Helens Safeguarding Children Partnership

Place	Safeguarding Adults Board	Safeguarding Children Partnership
Warrington	Warrington Safeguarding Adults Board (WSAB)	Warrington Safeguarding Partnership
Wirral	Wirral Safeguarding Adults Partnership Board	Wirral Safeguarding Children Partnership

6. EQUALITY STATEMENT

6.1. Equality, diversity, and human rights are central to the work of the Cheshire and Merseyside Integrated Care Board. This means ensuring local people have access to timely and high-quality care that is provided in an environment which is free from unlawful discrimination. It also means that the Integrated Care Board will tackle health inequalities and ensure there are no barriers to health and wellbeing.

6.2. To deliver this work Integrated Care Board staff are encouraged to understand equality, diversity, and human rights issues so they feel able to challenge prejudice and ensure equality is incorporated into their own work areas. Integrated Care Board staff also have a right to work in an environment which is free from unlawful discrimination and a range of policies are in place to protect them from discrimination.

6.3. The Integrated Care Boards' equality, diversity and human rights work is underpinned by the following:

a. NHS Constitution 2015
b. Equality Act 2010 and the requirements of the Public Sector Equality Duty of the Equality Act 2010
c. Human Rights Act 1998
d. Health and Social Care Act 2012

6.4. Equality analysis is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages. There are two reasons for this:

1. To consider if there are any unintended consequences for some groups.
2. To consider if the policy will be fully effective for all target groups.

Part B

7. MENTAL CAPACITY ACT PRINCIPLES

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

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

7.2. There are five key principles underpinning the Act that put the individual at the centre of decision making and provides a framework for staff when providing care and treatment:

Principle	Description
Principle 1 **Assume Capacity:**	Every adult has the right to make their own decisions if they have capacity to do so. An individual must therefore always be assumed to have capacity unless it is established otherwise.
Principle 2 **Practical steps to maximise decision making capacity:**	An individual is not to be treated as unable to make a decision unless all practicable steps to help him/her make the decision have been taken without success
Principle 3 **Unwise decisions:**	An individual is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision
Principle 4 **Best Interest:**	Any act done, or decision made, under the Act for or on behalf of an individual who lacks capacity must be done or made in his\her best interests.
Principle 5 **Less Restrictive Alternative:**	Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the individuals' rights and freedom of action.

Further information can be found in [Chapter 2 of the MCA Code of Practice]

8. WHEN IS A MENTAL CAPACITY ACT ASSESSMENT NEEDED?

8.1. Decision making capacity refers to an individual's ability to make decisions and take actions for themselves, from everyday decisions such as what to eat, to more significant ones such as whether to accept or refuse serious medical treatment.

8.2. An individual lacks capacity in relation to a matter if, at the material time, they are unable to make a decision for themselves in relation to the matter.

8.3. Capacity assessments refer to an individual's ability to make a particular decision at a particular moment in time; they are not a blanket judgment on an individual's ability.

8.4. When a decision needs to be made, but there is concern that the individual may lack capacity then an assessment of the urgency of the decision needs to be made:

8.5. **When an urgent decision needs to be made:**
It is possible to treat someone if a clinician reasonably believes an individual lacks capacity to consent to the specific treatment and that the treatment is in their best interests and necessary to save their life or to prevent a significant deterioration in their condition - do what is immediately necessary to prevent serious harm and to pass the point of crisis.

8.6. The individual's capacity to make the decision and their best interest need to be considered and demonstrated in documentation following the delivery of care and treatment that is immediately necessary. Consideration should also be made to keep the individual as informed as possible during the care/treatment as appropriate.

8.7. **When the decision is not urgent**
If the individual is likely to regain capacity, the decision should be delayed until such a time that the individual has the capacity to make the decision for themselves.

9. WHO SHOULD ASSESS MENTAL CAPACITY?

9.1. The individual who assesses an individual's capacity to make a decision will usually be the individual who is directly concerned with the individual at the time the decision needs to be made. The individual is the decision maker.

9.2. This means that different people will be involved in assessing an individual's capacity to make different decisions at different times. The decision as to who is the best individual to assess for capacity depends on the decision that needs to be made.

9.3. For more complex decisions and assessments it may be necessary to utilise other specialist professionals when undertaking capacity assessments so that all the relevant information and risks/benefits of the decision to be made can be explained following principle 2 of the Act. For example, it may be necessary to involve a Speech and Language Therapist or dietitian to provide information about the risks and benefits of a particular decision.

9.4. The Act is designed to empower those in health and social care to undertake capacity assessments themselves, rather than rely on expert testing by psychiatrists or psychologists unless that is required in complex cases. Other factors will indicate other professional involvement, and these include:

a. The gravity of the decision or its consequence.

b. Where the individual concerned disputes a finding of incapacity.

c. Where there is disagreement between family members, carers and/or professionals as to the individual's capacity.

d. Where the individual concerned is expressing different views to different people, perhaps through trying to please them.

e. Where there is concern that undue pressure or coercion is being placed on the individual, their carers or others.

f. Where there may be legal consequences to a finding of lack of capacity.

10. HOW TO COMPLETE A MENTAL CAPACITY ASSESSMENT:

10.1. The two-stage test

When there is cause to doubt that an individual has capacity to make a particular decision a two-stage capacity test should be undertaken. There should be a link between the two elements that is the diagnosis and the functional element:

1. Functional Element

Is the impairment/disturbance will cause the individual to be unable to do one of the following four tests for the time and specific decision:

1. **Understand** the information relevant to the decision: the individual only needs to understand the basic key relevant information around the decision and information should be accessible to that individual.

2. **Retain** the information long enough to make a decision: use of support like memory aids does not mean lack of capacity.

3. **Use or weigh the information** to make a decision: Can they consider the risks, benefits, and consequences relevant to the decision while they actually make the decision?

4. **Communicate** the decision by any means including sign language, writing, behavior.

If the individual can understand, retain, use and weigh information and communicate the decision then are deemed to have capacity for the decision in question.

2. Diagnostic Element

1. What evidence is there of 'an impairment of or a disturbance in the functioning of the mind or brain, whether temporary or permanent?'

Examples of this may include:

a. Dementia
b. Significant learning disabilities
c. The long-term effects of brain injury
d. Physical or mental conditions that cause confusion, drowsiness or loss of consciousness
e. Delirium
f. Concussion following a head injury
g. Symptoms of substance misuse

10.2. *If there is no impairment of, or disturbance in the functioning of, their mind or brain, the individual does not lack capacity for the purposes of the Act.*

10.3. Supporting people to make their own decisions

When working with an individual who needs to make a decision, those working with them must start from the presumption that the individual has capacity. It is therefore the responsibility of the assessor to take all practicable steps to help someone make their own decisions before they can be regarded as unable to make a decision.

10.4. In supporting an individual to make a decision consideration should be given to the questions below. All information relevant to the decision must be explained to the individual, including risks, benefits and consequences. It must include the information likely to be important to the individual. This will require a balance to be struck between giving enough information to make an informed decision and too much information or detail which could be confusing:

1. Has the individual been provided with all the relevant information needed to make the decision in question including benefits, risks and consequences?

2. Could the information be explained or presented in a way that is easier for the individual to understand?

3. Are there times of day when the individual's understanding is better or locations where they feel more at ease?

4. Can the decision be put off until the circumstances are right for the individual concerned?

5. Can anyone else help or support the individual to make choices or express a view, such as an independent advocate, family or someone to assist communication?

10.5. **There are decisions that cannot be made on behalf of others regardless of their capacity:**

1. Consent to marriage or a civil partnership, or a decree of divorce on the basis of two years separation or to the dissolution of a civil partnership on the basis of two years separation.

2. Consent to have sexual relations.

3. Consent to a child being placed for adoption or the making of an adoption order.

4. To discharge parental responsibilities for a child in matters not relating to the child's property.

5. To give consent under the Human Fertilisation and Embryology Act 1990.

6. No one can vote on behalf of an individual who lacks capacity.

10.6. **Recording Assessments of Capacity**

Where there are concerns around whether the individual has the capacity to consent or refuse to the treatment or act, or to make a specific decision, a formal assessment of mental capacity must be carried out and recorded on the individual's record.

10.7. A form need not always be used as in most cases assessment of capacity will take place on a regular, more informal level, related to the care and support of the individual.

10.8. However, there may be serious decisions that may need to be made on an individual's behalf where it is concluded they may lack the mental capacity. These situations could create some legal challenge and it is particularly important that there is clearly documented evidence of the assessment of capacity in the individual's records, including:

a. The decision is about serious medical treatment.
b. The decision concerns longer term accommodation changes.
c. There is a lack of concurrence about whether or not the individual lacks capacity for the decision.

d. There is an intention to refer to the Independent Mental Capacity Advocate.
e. There is a need to have a specific record of the assessment and such a form would be useful.
f. There are concerns about conflicting opinions (e.g., between professionals, carers, the individual being assessed).
g. Where there might be some significant difference of opinion around the decision to be made.

10.9. If the outcome of the capacity assessment is that the individual has capacity to make the decision, the act of care or treatment must be authorised by the individual's consent. There must be a statement acknowledging this in the individual's case notes.

10.10. Professionals are subject to higher standards in terms of record keeping and a formal record will be required to be kept, for example in the patient's clinical notes if a doctor or a healthcare professional is proposing treatment for someone who lacks capacity.

10.11. The Mental Capacity Assessment form template can be found in **Appendix 1** or for NHS Continuing healthcare decision use the Mental Capacity Act and Best Interest template in **Appendix 3.**

11. BEST INTEREST DECISION MAKING

11.1. If an individual has been assessed as lacking capacity, then any act done for, or decision made on behalf of the individual lacking capacity must be done or made in the individual's best interests. That is the same whether the person making the decision or acting is a family carer, paid care worker, an attorney, court-appointed deputy, or healthcare professional.

11.2. As long as these acts or decisions are in the best interests of the person who lacks capacity to make the decision for themselves or to consent to acts concerned with their care or treatment, then the decision-maker or carer will be protected from liability.

11.3. There are exceptions to this, including circumstances where a person has made an advance decision to refuse treatment and, in specific circumstances, the involvement of a person who lacks capacity in research. But otherwise, the underpinning principle of the Act is that all acts and decisions should be made in the best interests of the person without capacity.

11.4. Working out what is in someone else's best interests may be difficult, and the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person's best interests. In some cases, there may be disagreement about what someone's best interests really are. As long as the person who acts or makes the decision has followed the steps to establish

whether a person has capacity and done everything, they reasonably can work out what someone's best interests are, the law should protect them.

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

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

11.6. However, certain decisions are outside of the framework of best interests in the Act, and they may require the Court of Protection to make the particular decision. Sections 27-29 and 62 of the Act set out such decisions. These include:

a. Decisions concerning family relationships (section 27) e.g., consenting to sexual relations, consent to marriage, divorce, a child being placed for adoption or the making of an adoption order.

b. Mental Health Act matters e.g., treatment under Part 4 the Mental Health Act 1983 amended 2007.

c. Voting rights (section 29)

d. Unlawful killing or assisted suicide (section 62)

12. BEST INTEREST CHECKLIST AND CONSIDERATIONS

12.1. Section 4 of the Act sets out a checklist of factors that must be considered when a best interest's decision needs to be made for an individual assessed as lacking the capacity to make the decision. This checklist is the starting point, in many cases additional individual factors will need to be considered.

12.2. In determining what is in an individual's best interests, the person making the determination must not make it merely based on:

a. the individual's age or appearance, or
b. a condition of their, or an aspect of their behaviour, which might lead others

to make unjustified assumptions about what might be in their best interests.

12.3. A person trying to determine the best interests of a person who lacks capacity to make a particular decision should:

a. 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.
b. Identify all relevant circumstances - Try to identify all the things that the person who lacks capacity would consider if they were making the decision or acting for themselves.
c. Find out the person's views - try to find out the views of the person who lacks capacity, including:
    I. The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behavior or habits.
    II. Any beliefs and values (e.g., religious, cultural, moral, or political) that would be likely to influence the decision in question.
    III. Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.
    IV. Not make assumptions about someone's best interests simply based on the person's age, appearance, condition, or behavior.
    V. 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?
    VI. If the decision concerns life-sustaining treatment - not be motivated in any way by a desire to bring about the person's death.
    VII. Not make assumptions about the person's quality of life.

12.4. The person making the determination must consider all the relevant circumstances and take the following steps:

a. Consider whether it is likely that the individual may have capacity at some time in the future and consider if thew decision can wait.
b. Encourage, as far as is reasonably practicable, the individual to participate in any action undertaken for him or in any decision affecting him.
c. Should not be motivated by a desire to bring about the individual's death when the decision relates to life-sustaining treatment.
d. Consider the individual's past and present wishes and feelings.
e. Consider any relevant written statement made when the individual had capacity.
f. Consider the beliefs and values that would be likely to influence the individual's decision, for example, religious, cultural and lifestyle choices.
g. Consider other factors the individual would be likely to consider if he were able to do so. For example, emotional bonds or family obligations in deciding how to spend money or where to live.
h. Consider whether you need to involve an Independent Mental Capacity Advocate for Significant decisions e.g., serious medical treatment or changes of accommodation.

i. Consult and consider the view of other key people as to what would be in the individual's best interests including:
   I. Anyone named by the individual as someone to be consulted.
   II. Any carer, close relative, close friend or anyone else interested in the individual's welfare.
   III. Any attorney appointed under Lasting Power of Attorney.
   IV. Any Court appointed deputy appointed by the Court of Protection.

12.5. **DECISION MAKER**

Under the Act many different people may be required to make decisions or act on behalf of someone who lacks capacity to make a particular decision for themselves. The individual making the decision is referred to as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the individual who lacks capacity.

12.6. Careful consideration should be given to who the decision-maker is:

a. Where a deputy has been appointed by the Court of Protection to make welfare decisions.
b. such as the one in question then the deputy will be the decision-maker.
c. If an attorney has been appointed under a Lasting Power of Attorney to make such decisions, then the attorney will be the decision-maker.
d. In the absence of a deputy or attorney, the decision-maker will be the individual responsible for the act of care or treatment in question.

12.7. **DISPUTES**

Sometimes, there might be disagreement or dispute as to what would be in the best interests of an incapacitated individual, for example between clinicians and family members. In the event of a dispute, staff should seek local resolution where possible.

12.8. The following may assist the decision maker to resolve the dispute:

1. Involve an advocate who is independent of all parties involved
2. Get a second opinion as to capacity and/or best interests
3. Hold a strategy meeting of all involved
4. Consider mediation

12.9. Where local resolution of a dispute is not possible despite all efforts of the decision-maker, consider with line management whether a legal perspective should be obtained. The Court of Protection has jurisdiction to resolve disputes as to the capacity and/or best interests of an incapacitated individual, and an application to the Court might be necessary in some cases. Advice should be

sought from the Integrated Care Board Safeguarding Service before finalising any decisions to seek legal advice with a view to approach the Court of Protection.

12.10. **HOW TO DOCUMENT A BEST INTEREST DECISON**

It is often not necessary to hold a Best Interests Meeting to formalise the decision making but it is always necessary to record the best interest's decision.

12.11. Best interests' assessments must be documented appropriately using the best interest decision recording template in **Appendix 2 or** for NHS Continuing healthcare decision use the Mental Capacity Act and Best interest template in **Appendix 3.**

12.12. **CARE AND TREATMENT**

Section 5 of the Act allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the individual care, healthcare or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the individual who lacks capacity to consent to the intervention in question. Section 5 should not be relied on when there are disputes or doubts to capacity and best interest.

12.13. Section 5 (1) provides possible protection for actions carried out in connection with care or treatment. The action may be carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in that individual's best interests. The Act does not define 'care' or 'treatment'. Actions that might be covered by section 5, in relation to individual care, include:

a. Helping with washing, dressing or individual hygiene
b. Helping with eating and drinking
c. Helping with communication
d. Helping with mobility
e. Providing services that help around the home (such as homecare or meals on wheels)
f. Undertaking actions related to community care services (for example, day care, residential accommodation or nursing care)
g. Helping someone to move home (including moving property and cleaning the former home)

12.14. In relation to healthcare and treatment:

a. Carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
b. Providing professional medical, dental and similar treatment
c. Giving medication
d. Taking someone to hospital for assessment or treatment
e. Providing nursing care (whether in hospital or the community)
f. Carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example physiotherapy or chiropody)

g. Providing care in an emergency

12.15. Some acts in connection with care or treatment may cause major life changes with significant consequences for the individual concerned and as a result require careful consideration. Examples include a change of residence, perhaps into a care home or nursing home, or major decisions concerning healthcare or medical treatment.
Further information can be found in Chapter 6 of the MCA Code of Practice

13. LIMITATIONS OF PROTECTION FROM LIABILITY

13.1. Professionals will be protected from liability under section 5 of the Act, if they can demonstrate that they have taken appropriate steps to assess capacity, reasonably believe that the individual lacks capacity and can evidence that they have carried out a best interest assessment and reasonably believe that the act is in the individuals' best interests.

13.2. **Section 5** does not provide a defense in cases of negligence – either in carrying out a particular act or in failing to act where necessary.

13.3. **Section 6 (5)** makes it clear that an act depriving a person of his or her liberty cannot be an act to which section 5 provides any protection.

14. INDEPENDENT MENTAL CAPACITY ADVOCATES

14.1. Independent Mental Capacity Advocates are intended to provide a safeguard for those who lack capacity to make decisions about receiving serious medical treatment or changes in accommodation, and who do not have family or friends to support them in that process. An advocate may also be instructed where an individual does have family and friends, but it would not be appropriate to consult with them about such decisions. Whether an individual is appropriate to consult may relate, for example, to whether they can be contacted, whether they are willing and able to be consulted or to represent the individual, or there are any safeguarding concerns.

14.2. **When an Independent Mental Capacity Advocate MUST be instructed**
Where an individual lacks capacity to make a particular decision and is 'un-befriended' as described above, decision makers in local authorities and NHS Trusts have a duty to instruct an Independent Mental Capacity Advocate where:

1. It is proposed by the NHS or Local Authority that the individual be moved to long-term care, of more than 28 days in hospital or 8 weeks in a care home (where that accommodation or move is not a requirement of the Mental Health Act)

2. The NHS or Local Authority is proposing a long-term move (8 weeks or more) to different accommodation, for example a move to a different hospital or care home (where that accommodation or move is not a requirement of the Mental Health Act).

3. care reviews about accommodation or changes to accommodation

4. adult protection cases where the individual without capacity is, or has been abused, or has been an abuser, but only where protective measures have been, or are proposed to be taken (this applies even if the individual who lacks capacity has family and/or friends).

5. The decision is about serious medical treatment provided by or proposed by the NHS (but excludes treatment regulated under part 4 of the Mental Health Act), examples of possible serious medical treatments:

   I. Chemotherapy and surgery for cancer
   II. Electro-convulsive therapy
   III. Therapeutic sterilisation
   IV. Major surgery (such as open-heart surgery or brain / neurosurgery)
   V. Major amputations (e.g., loss of arm or leg)
   VI. Treatments which will result in permanent loss of hearing or sight
   VII. Withholding or stopping artificial nutrition or hydration
   VIII. Termination of pregnancy

14.3. The above are examples only, and whether these or other procedures are considered serious medical treatment in any given case, will depend on the circumstances and the consequences for the individual. It could be that the provision of antibiotics could be considered serious medical treatment where there are serious consequences if treatment is not provided.
For more information see Serious Medical Treatment – Practice Guidance (Essex Chambers)

14.4. **The only situation in which the duty to instruct am Independent Mental Capacity Advocate need not be followed is when an urgent decision is needed (e.g., to save the individual's life).**
Any such decision must be recorded with the reasons for the non-referral. Responsible bodies, however, still need to instruct an Independent Mental Capacity Advocate for any serious medical treatment that follows the emergency treatment.

15. ADVANCE CARE PLANNING

15.1. Practitioners should encourage individuals to think about the future in terms of how they want decisions to be made should they lose capacity to make some decisions. Individuals can express their choices and ensure their voice is heard and practitioners document the persons wishes and options.

15.2. **Advance Decisions to Refuse Treatment**

People with capacity over the age of 18 years, are able to make advance decisions regarding refusal of health treatments, which will relate mainly to medical decisions, these should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.

15.3. Making an advance decision to refuse treatment allows particular types of treatment you would never want, to be honored in the event of losing capacity – this is legally binding and health care professionals must follow an Advance Decisions to Refuse Treatment decision when found to be valid and applicable.

15.4. Practitioners must take all reasonable efforts to check if an advanced decision exists, and that it is valid and applicable to the particular treatment in question. Reasonable steps would include, checking the records, asking the patient, their friends or family, and checking with the GP if one is known or recorded. Reasonable steps are dependent on the urgency and nature of the treatment in question.

15.5. The Act introduces a number of rules you must follow. Therefore, a person making an Advance Decisions to Refuse Treatment should check that their current advance decision meets the rules if it is to take effect. An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive, which without they may die) this must be in writing.

15.6. Life sustaining advance decisions must:

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

15.7. This does not change the law on euthanasia or assisted suicide. A person cannot ask for an advance decision to end their life or request treatment in future. The validity of an advance decision may be challenged on the following grounds:

a. If the Advance Decision is not applicable to this treatment decision.
b. If it is treatment for a mental disorder, treatment could be given under the Mental Health Act if the criteria for this are met.
c. If the relevant person changes their mind.
d. If they do a subsequent act that contradicts the Advance Decision.
e. They have appointed a Lasting Power Of Attorney for Health and Welfare after the date of the Advance Decision.

15.8. Integrated Care Board staff responsible for treatment and care, for example continuing health care staff, must be aware of the responsibilities of staff for receiving and recording Advance Decisions to Refuse Treatment whether written or verbal. They must be able to establish the validity of existing Advance Decisions to Refuse Treatment and whether or not they are relevant for an individual given their current situation.

15.9. **Advance Statements / Decisions**

Advance statements/decisions are evidence of a person's wishes and preferences regarding care and treatment. Unlike Advance Decisions to Refuse Treatment's they are not legally binding however should be considered by the practitioner in decisions of best interest. They are evidence of the person's wishes and feelings and may provide a clear indication of what the person would have wished for when capacitated to make the relevant decision for themselves. Statements of preference often form part of anticipatory care planning; treatment escalation plans and end of life care planning.

16. LASTING POWER OF ATTORNEY

16.1. This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reached effects for healthcare workers because the Act extends the way people using services can plan ahead for a time when they lack capacity.

16.2. A power of attorney is a legal document that allows one individual (the donor) to appoint one or more people (known as 'attorneys') authority to make decisions on their behalf which are as valid as if made by the individual themselves. An individual must be 18 years or over and have mental capacity (the ability to make your own decisions) when they make a Lasting Power Of Attorney.

16.3. There are 2 types of Lasting Power Of Attorney and individuals can have one or both types:

1. Health and Welfare (decisions around health care and consent to medical treatment).

2. Property and Financial affairs (decisions around financial matters and property).

16.4. The Act replaced the previous Enduring Power of Attorney with the Lasting Power Of Attorney but Enduring Power Of Attorney made prior to the amendment on 1st October 2007 are still valid.

16.5. **Individual Welfare Lasting Power Of Attorneys**

Lasting Power Of Attorney can be used to appoint attorneys to make decisions about individual welfare, which can include health care and medical treatment decisions. Individual welfare Lasting Power Of Attorney might include decisions about:

a. Where the donor should live and who they should live with.
b. The donor's day to day care, including diet and dress.
c. Who may the donor have contact with?
d. Consenting to or refusing medical examination and treatment on the donor's behalf.
e. Arrangements needed for the donor to be given medical, dental or optical treatment.
f. Assessments for and provision of community care service.
g. Whether the donor should take part in social activities, leisure activities, education or training.
h. The donor's individual correspondence and papers.
i. Rights of access to individual information about the donor, or
j. Complaints about the donor's care or treatment.

16.6. The standard form for individual welfare Lasting Power Of Attorney allows attorneys to made decisions about anything that relates to the donor's individual welfare. However, donors can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare.

16.7. A general individual welfare Lasting Power Of Attorney gives the attorney the right to take all decisions set out above although this is not a full list of actions they can take or decisions they can make. The Attorney is the best interest's decision maker, so bound by the Act including consultation duties. Any decision not in the individual's best interests can and should be challenged. An individual welfare Lasting Power Of Attorney can only be used at a time when the donor lacks capacity to make a specific welfare decision.

16.8. An individual welfare Lasting Power Of Attorney allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the Lasting Power Of Attorney that they do not want the attorney to make these decisions.

16.9. Even, where the Lasting Power Of Attorney includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

1. The donor has capacity to make the particular decision.
2. The donor has made an advance decision to refuse the proposed treatment.

16.10. An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment.

a. However, if the donor made a Lasting Power of Attorney after the advance decision and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the Advance Decisions to Refuse Treatment.
b. A decision relates to life-sustaining treatment.
c. An attorney has no power to consent to or refuse life-sustaining treatment, unless the Lasting Power of Attorney document expressly authorises this.
d. The donor is detained under the Mental Health Act.
e. An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act.

16.11. CONFIRMING A LASTING POWER OF ATTORNEY

If an individual has appointed an attorney under a Lasting Power Of Attorney, it is essential that any member of staff wishing to make a decision or carry out an act can document and satisfy themselves that the attorney has the necessary authority to make decisions on behalf of the individual lacking capacity, or that they must be consulted.

16.12. For any Power of Attorney document to be valid and binding, it must be registered with the Office of the Public Guardian. They can be contacted to carry out a search on three registers which they maintain, these being registered Lasting Power Of Attorneys, registered Enduring Power Of Attorneys and the register of Court ordered Appointed Deputies.

16.13. Any staff member wanting to confirm that a Lasting Power Of Attorney or Enduring Power Of Attorney is valid i.e., registered, not revoked and the attorney has not been removed one can check using the link below

16.14. Further information regarding the Office of the Public Guardian including all the forms to make powers of Attorney, can be found by the following link: http://www.publicguardian.gov.uk/

16.15. THE COURT OF PROTECTION

Section 45 of the Act established the Court of Protection, to deal with specific decision-making for adults (children in a few cases) who lack capacity to make specific decision for themselves. As well as property and affairs, the Court also deals with serious decisions affecting healthcare and individual welfare matters.

16.16. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision.

16.17. The Court of Protection is a superior Court of record and is able to establish precedent (it can set examples for future cases) and build up expertise in all issues related to lack of capacity. It has the same powers, rights, privileges and authority as the High Court.

16.18. When reaching any decision, the Court must apply all the statutory principles. In particular, it must make a decision in the best interests of the individual who lacks capacity to make the specific decision.

16.19. The Court of Protection has the powers to:

a. Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
b. Appoint deputies to make decisions for people lacking capacity to make those decisions.
c. Decide whether a Lasting Power Of Attorney or Enduring Power Of Attorney is valid; and remove deputies or attorneys who fail to carry out their duties.
d. Hear cases concerning objections to register a Lasting Power Of Attorney or Enduring Power Of Attorney and make decisions about whether or not a Lasting Power Of Attorney or Enduring Power Of Attorney is valid.

16.20. Cases involving any of the following serious medical treatment decisions must be brought before a Court:

a. Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (from patients in a permanent vegetative state in particular where there are different opinions.
b. Cases involving organ or bone marrow donation by an individual who lacks capacity to consent.
c. Case involving the proposed non-therapeutic sterilisation of an individual who lacks capacity to consent to this (e.g., for contraceptive purposes), and
d. All other cases where there is a doubt or dispute about whether a particular treatment will be in an individual's best interests.

16.21. If a decision is required that may involve the Court of Protection, advice and guidance should be sought from the Integrated Care Board Safeguarding Service, in your area, in the first instance.

16.22. Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link: https://www.gov.uk/courts-tribunals/court-of-protection

16.23. **Court Appointed Deputies**
Sometimes, it is not practical or appropriate for the Court to make a single declaration or decision. In such cases, if the Court thinks that somebody needs to make future or ongoing decisions for someone whose condition makes it likely

they will lack capacity to make some further decisions in the future; it can appoint a deputy to act for and make decisions for that individual:

16.24. In most cases, the deputy is likely to be a family member or someone who knows the individual well.

16.25. Deputies must be at least 18 years of age.

a. Deputies with responsibility for property and affairs can be either an individual or a trust corporation (often parts of banks or other financial institutions).
b. Paid care workers (for example, care home managers) should not agree to act as a deputy because of the possible conflict of interest – unless there are exceptional circumstances (for example, if the care worker is the only close relative of the individual who lacks capacity).
c. The Court can appoint someone who is an office holder or in a specified position (for example, the Director of Adult Services for the relevant local authority). In this situation, the Court will need to be satisfied that there is no conflict of interest before making such an appointment.

16.26. Once a deputy has been appointed by the Court, the order of appointment will set out their specific powers and the scope of their authority. On taking up the appointment, the deputy will assume several duties and responsibilities and will be required to act in accordance with certain standards.

16.27. Failure to comply with the duties set out below could result in the Court of Protection revoking the order appointing the deputy and, in some circumstances; the deputy could be individually liable to claims for negligence or criminal charges of fraud. Deputies should always inform any third party they are dealing with, that the Court has appointed them as deputy. The Court will give the deputy official documents to prove their appointment and the extent of their authority.

16.28. A deputy must act whenever a decision or action is needed, and it falls within their duties as set out in the Court order appointing them. A deputy who fails to act at all in such situations could be in breach of duty. When dealing with an individual who claims to be the court-appointed deputy of an incapacitated individual, staff should ask to see a copy of the sealed court order, which gives the deputy their authority. Staff should also check the order to confirm the nature and extent of the attorney's authority to make decisions.

16.29. Deputies are accountable to the Court of Protection. The Court can cancel a deputy's appointment at any time if it decides the appointment is no longer in the best interests of the individual who lacks capacity.

16.30. The Office of Public Guardian is responsible for supervising and supporting deputies. However, it must also protect people lacking capacity from possible abuse or exploitation.

16.31. Anybody who suspects that a deputy is abusing his or her position should contact the Integrated Care Board Safeguarding Service and the Office of Public Guardian immediately. They may instruct a Court of Protection Visitor to visit a deputy to investigate any matter of concern. It can also apply to the Court to cancel a deputy's appointment.

16.32. The Office of Public Guardian will carefully consider any concerns or complaints against the deputies. However, if somebody suspects physical or sexual abuse or serious fraud, they should contact the police and/or social services immediately, as well as informing the Office of Public Guardian.

16.33. **OFFENCES**

It is an offence to ill-treat or willfully neglect an individual who lacks capacity to make relevant decisions and penalties will range from a fine to a sentence of imprisonment of up to five years or both. Ill-treatment and neglect are separate offences. For an individual to be found guilty of ill treatment, they must either:

1. Have deliberately ill-treated the individual, or
2. Been reckless as to whether they were ill-treating the individual or not.

16.34. It does not matter whether the behavior was likely to cause, or actually caused harm or damage to the victim's health.

16.35. The meaning of 'willful neglect' varies depending on the circumstances. It usually means that an individual has deliberately failed to carry out an act they knew they had a duty to do. Allegations of offences may be made to the police or the Office of the Public Guardian. They can also be dealt with under safeguarding procedures and advice sought from our safeguarding service.

17. RESTRAINT

17.1. The Act defines restraint as the use or threat of force to make someone do something, they are resisting or to restrict an individual's freedom of movement whether they are resisting or not.

17.2. If the act of care or treatment involves restraint staff will only be protected from liability if the individual lacks capacity to consent to the act and if the restraint is in the individual's best interests. The following conditions should all be met:

a. The individual taking action should reasonably believe that the restraint is necessary to prevent harm to the individual who lacks capacity; and
b. The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.
c. There is no less restrictive option to meet the need

d. If the effects of the restriction amount to a deprivation of liberty, then this must be specifically authorised and included in the individuals care plan and all instances of restraint clearly documented.

17.3. Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy. Examples of these include using covert medication, the use of physical force to prevent someone doing something, the use of mechanical restrictions (e.g., bed sides) and the use of verbal threats. This may include having the external door to a unit locked to prevent a patient wandering off into a potentially dangerous situation

18. CONSENT TO TREATMENT

18.1. A fundamental principle of the law on consent to treatment is that:

1. Every individual has the right to make their own decisions about care and treatment unless there is evidence to show that they lack capacity to make a particular decision when it needs to be made.
2. Consent should be sought for any medical or care intervention and failure to do so endangers health and care workers of the risk of breaching key human rights for the individual and of the risk of both criminal and civil litigation.
3. When consent for medical treatment or examination or care is required, the doctor or practitioner proposing the treatment or intervention should decide whether the patient has the capacity to consent or refuse the treatment or intervention. Ultimately, it is up to the professional responsible for the individual’s treatment or intervention to make sure that capacity has been assessed and to involve relevant others.

19. DEPRIVATION OF LIBERTY SAFEGUARDS

19.1. The Deprivation of Liberty Safeguards framework came in force in April 2009.Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of individual. No one shall be deprived of his or her liberty (unless) in accordance with a procedure prescribed in law'.

19.2. The Deprivation of Liberty Safeguards is the procedure prescribed in law under the Mental Capacity Act. 2005. An application must be made when it is necessary and proportionate to deprive the liberty of an individual who lacks capacity to consent to their care and or treatment to keep them safe from harm and to do what is in their best interests. Deprivation of Liberty Safeguards applies to all those who are aged 18 years old and above.

19.3. The aim of the Deprivation of Liberty Safeguards is to:

a. Provide safeguards for people who lack capacity to decide where and how to be accommodated for care/treatment.
b. Ensure people are given the care they need in the least restrictive way.
c. Prevent decisions being made to suit the home or hospital rather than the needs of the adult at risk.
d. Entitle people to take proceedings by which the lawfulness of a deprivation will be decided speedily by a court and release ordered if the deprivation is seen as unlawful.

19.4. DEPRIVATION OF LIBERTY IN HOSPITAL AND CARE HOMES

Deprivation of Liberty Safeguards cover patients in hospitals (including hospices) and people in care homes whether placed under public or private arrangements.

19.5. A Deprivation of Liberty Safeguards authorisation cannot be used to authorise a deprivation of liberty taking place in a children's home. The Court of Protection can authorise the deprivation of an individual's liberty from the age of 16. Under the age of 16 years, a deprivation of liberty must be authorised under inherent jurisdiction of the High Court.

19.6. DEPRIVATION OF LIBERTY IN DOMESTIC SETTINGS

A deprivation of liberty can occur in domestic settings where the state is aware of or responsible for imposing such arrangements.

19.7. This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements it must be authorised by the Court of Protection. Applications are made to the court of protection with necessary assessments to show that the criteria for a deprivation of Liberty have been met.

19.8. DEPRIVATION OF LIBERTY: CHILDREN AND YOUNG PEOPLE

The criteria for a deprivation of liberty (see below) are the same for children and young people as it is for adults. Children under the age of 16 would usually not fall into the remit of deprivation of liberty legislation as those with parental responsibility are able to consent to the care arrangements on their children's behalf.

19.9. Parents cannot consent to a deprivation of liberty for children aged 16-17 years.

19.10. Where a child is subject to care arrangements and the Local Authority has parental responsibility for the child, the Local Authority cannot consent to a deprivation of liberty on behalf of the child. In these circumstances an application needs to be made (either inherent jurisdiction of the High Court order for those under 16 years old or to the Court of Protection for 16-17 years old children).

19.11. The law concerning a deprivation of liberty for children and young people is still developing and it is therefore important that advice is sought when looking at cases of deprivation of liberty for Children.

19.12. THE THRESHOLD FOR A DEPRIVATION OF LIBERTY

To meet the threshold for a deprivation of liberty the following conditions have to be met:

a. **The objective test**: is the individual confined?
b. **The acid test**:

Is the individual under 'continuous supervision and control' not for a negligible time and not free to leave (The individual may not be saying this or acting like they want to leave but the issue is about how staff would react if the individual did try to leave, if they will stop the individual then the individual is not free to leave)?

c. **The subjective test**: is there valid consent? The individual has to lack capacity to give valid consent to the care arrangements.
d. **Immutability to the state:** Is the arrangement imputable to the state? – Is the state aware of the arrangements or have responsibility for the arrangements

19.13. The following factors are not relevant to the decision that an individual is being deprived of their liberty:

a. The Individual is compliant or does not object.
b. The placement is relative normal, and
c. The reason or purpose behind or quality of a particular placement.

19.14. APPLICATIONS FOR AUTHORISING DEPRIVATION OF LIBERTY

There are situations where it is necessary to deprive someone of their liberty in order to protect them from harm in their best interest. Having this deprivation authorised is a legal requirement and provides the individual with safeguards to further safeguard their human rights.

19.15. Where responsible staff within a Managing Authority (Care Home, or Hospital) think there is a need to deprive someone of their liberty or they may need to deprive someone in the future, they have to ask for this to be authorized by a Local Authority as a Supervisory Body. They can do this up to 28 days in advance of when they plan to deprive the individual of their liberty.

19.16. For care homes and hospitals, the Supervisory Body is the local authority where the individual is ordinarily resident. Usually this will be the local authority where the care home is located unless the individual is funded by a different local authority.

19.17. The Managing Authority must fill out a form requesting a standard authorisation. This is sent to the supervisory body which has 21 days to decide whether the individual can be deprived of their liberty. The authorisation process involves independent assessments, and these inform the Supervisory Body's decision to either grant or not grant the authorisation. There are six criteria that must be assessed and fulfilled for the authorisation to be granted.

19.18. The Managing Authority can deprive an individual of their liberty for up to seven days using an urgent authorisation in circumstances where the care arrangements mean the individual is already being deprived of their liberty. It can only be extended (for up to a further seven days) if the supervisory body agrees to a request made by the managing authority to do this.

19.19. When using an urgent authorisation, the Managing Authority must also make a request for a standard authorisation and have a reasonable belief that a standard authorisation would be granted.

19.20. In the Integrated Care Board its highly likely there will need to be consideration of a deprivation of liberty in domestic settings. The deprivation of liberty must be authorised by the Court of Protection. Applications are made by the Continuing and Complex Health Care Service to the court of protection with necessary assessments to show that the criteria for a deprivation of Liberty have been met. The court will grant an order authorising the deprivation of liberty and set the review period. The order be for a period of 12 months or less depending on the situation and individual circumstances. If the situation is urgent the issue should be highlighted to the court of protection.

19.21. Length of the authorisation depends on individual circumstances and how likely it is these circumstances might change, though the maximum time allowed is 12 months. The assessor will make a recommendation based on the individual's best interests.

19.22. Integrated Care Boards, hospitals or care homes can request a new authorisation to begin as soon as the existing authorisation has run out.

19.23. The Deprivation of Liberty Safeguards authorisation and process comes with some safeguards for the individual
Examples of Safeguards:

a. Legal criteria for deprivation of liberty threshold to be met
b. Professional Assessors
c. Right to Appeal
d. Right to a Review
e. Right to advocacy and to a representative
f. Right to be informed of Rights
g. Right to be given copies of Assessments

h. The Care Quality Commission are required to monitor the operation of Deprivation of Liberty Safeguards

19.24. INTEGRATED CARE BOARD RESPONSIBILITES TO DEPRIVATION OF LIBERTY SAFEGUARDS

All Staff employed by the Integrated Care Board and practice members who visit, assess, treat, monitor and review patients residing in registered care establishments and or residing in hospitals should be aware of the Deprivation of Liberty Safeguards.

19.25. Where Integrated Care Board staff are aware of a potential deprivation of liberty in a domestic setting, they must explore and seek authorisation by the Court of Protection for the deprivation.

19.26. Staff must ensure the Act assessment and best interest process is followed before an application is made and should seek support and advice from their manager and safeguarding service as needed to start the process.

19.27. Integrated Care Board staff when commissioning and contracting services should ensure that service specifications and contacts are in line with the principles of the Act including elements of Deprivation of Liberty Safeguards. When in doubt they should engage with our safeguarding service to ensure that the rights of the those who are vulnerable due to possible lack of capacity to make some decisions are protected.

20. LIBERTY PROTECTION SAFEGUARDS

20.1. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making when there is a need to deprive them of their liberty. It is believed that the Liberty Protection Safeguards will work alongside the Deprivation of Liberty Safeguards process for twelve months on implementation.

20.2. There is no current date when the Liberty Protection Safeguards are planned to come into force and the policy will be updated to represent any change when the accompanying code of Practice and regulations are published.

20.3. More information on Liberty of Protection Safeguards can be found at Liberty Protection Safeguards

21. REFERENCES

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HM Government (2020) The Mental Capacity Act: Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Office of the Public Guardian (2008) Deprivation of Liberty Safeguards Code of Practice (Mental Capacity Act 2005): Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. TSO.London

Useful Resources

Deprivation of Liberty Safeguards at a glance

Mental capacity law and policy Mental-capacity-act-2005-at-a-glance by scie

Giving medicines covertly: NICE Guide

Liberty Protection Safeguards: what they are

Decision making and mental capacity (NG108) NICE Guidance

Mental Capacity Act 2005 and the Code of Practice (available from the Office of the Public Guardian).

Covert administration of medicines (Care Quality Commission).

APPENDIX 1: MENTAL CAPACITY ASSESSMENT TEMPLATE

Mental Capacity Assessment Form

This form relates for a person aged 16 years of age and over and has been developed to **support** your compliance with the Mental Capacity Act 2005. For more information please refer to the safeguarding pages on the ICB website, the Mental Capacity Act (MCA) Code of Practice - MCA Code of Practice or speak to the ICB Designated and Named Professionals for Safeguarding

Full name of Service user:	
Date of Birth:	
NHS Number:	
Present Address/Location:	
Home Address (if different):	

The assessor – usually the person who would be responsible for making the decision if the client lacks mental capacity to make it for themselves. For example, where consent to medical treatment is required, the health professional proposing the treatment has the responsibility of ensuring that capacity is assessed.

Name of Assessor:	
Job title / role:	
Work address and telephone number:	
Date and time of assessment:	

Section 1: The decision in question

Describe the decision that the person is making:	
Be as specific and accurate as you can. If there is more than one decision that requires assessment, record them on separate forms. If the decision is in regard to serious medical treatment. The practitioner who is responsible for persons' treatment to consider the implications of the proposal and decide if consequences are SERIOUS for the INDIVIDUAL. These may include starting, stopping or withholding treatment. Examples can range from blood tests, vaccinations, surgery, PEG insertion, dental treatment and DNACPR	
Do you need to involve anyone to help you to communicate with the person?	☐Yes ☐No
Please give the name and details of anyone who assisted with this assessment:	
Consider anyone else to provide information or give their opinion on the service users wishes, beliefs and feelings? This could include family members, friends, carers, social workers and other professionals	
Does the person require assistance with communication? Please detail support methods used:	

The person may communicate by talking, sign language, pictures or any other means. Consider the use of communication aids, interpreters, Speech and Language Therapists.
Does the person need any reasonable adjustments to support them? Please detail support methods used:
Reasonable adjustments can include assessing the person at an appropriate time, assessing them in a quiet room, allowing a person more time than would usually be allowed to provide further information, assess capacity and allow time for processing information by offering double appointments
What Are the values, beliefs and wishes of the person you are assessing for the decision in question?
All practicable steps must be taken to assist the person concerns express their views, beliefs, wishes and feelings

Section 2: The diagnostic test of capacity (stage one)

The Act requires assessors to have "reasonable belief" that a person lacks capacity in relation to a decision. If there is an established diagnosis of mental illness, learning disability, or some other condition then it is sufficient to confirm" impairment or disturbance of the mind". You do not need to involve other professionals unless the assessment is complex, when they can be asked to assist or provide a diagnosis

Q1 **Does the person have an impairment of, or disturbance in the functioning of their mind or brain?**	☐Yes ☐ No
E.g., symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term effects of an acute brain injury, confusion, drowsiness or loss of consciousness due to a physical or medical condition).	
If yes, please provide a brief summary of the diagnosis, the source of any information and how the diagnosis might impact on decision making:	
If no, the person can be deemed to have capacity and you should proceed to section 4.	

What is the nature of the impairment?	☐ Permanent ☐ Temporary ☐ Fluctuating
If temporary or fluctuating, please provide details:	
If the impairment is fluctuating or temporary? (Would it be appropriate to delay the assessment?) Date to re assess capacity:	☐Yes ☐ No
If yes, go to section 4.	If no, please why the delay is not appropriate:

Section 3: The functional test of capacity (stage two)

Having determined impairment or disturbance (Stage one) and given consideration to the ease, location and timing; relevance of information communicated; the communication method used; and others involvement, you now need to complete your assessment and form your opinion as to whether the impairment or disturbance is sufficient that the person lacks the capacity to make this particular decision at this moment in time. You must ensure that the information has been provided in a way that the person is able to understand.

Q2 Do you consider the person able to **UNDERSTAND** the information relevant to the decision?	☐ Yes ☐No
This includes the person's understanding of how the decision arose and the options available to them. Consider: What is their understanding of the decision in question? Can they tell you why they think the decision needs to be made? What do they think the consequences of the decision will be?	

Evidence the questions you asked, and the responses given

Q3 Do you consider the person able to **RETAIN** the information relevant to the decision?	☐Yes ☐No
The question of how long a person need retain information will vary as they need only remember significant information long enough to make an effective decision.	
Evidence the questions you asked, and the responses given	

Q4 Do you consider the person able to **USE or WEIGH UP** the information as part of the decision-making process?	☐Yes ☐No
Are they able to understand the consequences of making or not making the decision?	

Evidence the questions you asked, and the responses given

Q5 Do you consider the person able to **COMMUNICATE** their decision?	☐Yes ☐No
If required, consider other methods to communicate and if assistance may be required for example from a speech and language therapist or interpreter.	
Evidence the questions you asked, and the responses given	

How was the assessment completed?
Who was present, where did it happen, how did you support and enable the person to make their own decision?

Section 4: Determination of capacity

I consider that the person ***HAS*** the capacity to make the decision. ☐
The decision that the person has made is recorded below:
If you have answered YES consistently to Q2 to Q5, the person is considered on the balance of probability, to **Have** the mental capacity to make this particular decision at this point in time. **DO NOT PROCEED TO MAKE A BEST INTERESTS DECISION**
I consider that the person ***DOES NOT*** have the capacity to make the decision. ☐
If a person **lacks capacity** for a decision, then a best interest's decision should be made. Follow the best interest decision making process and complete the separate best interest decision making documentation

I consider that it is appropriate to delay this assessment until such time that the person is better able to demonstrate their capacity. ☐
Explain your reason(s) below:

For ongoing decisions, it will usually be important to review the person's capacity at regular intervals given that capacity can fluctuate and can improve or decline.
Where this applies, please indicate when the assessment should be reviewed below:

Section 5: Others Consulted

If the person is unable to make the decision themselves, is there someone with a Registered Lasting Power of Attorney (Enduring Power of Attorney under previous legislation), a Court Appointed Deputy, or person with parental responsibility (if person is under 18 years of age) with powers to make the decision which needs to be made?	☐ Yes ☐ No
Does this person/ attorney/deputy have the relevant authority in relation to this decision? Give details:	☐ Yes ☐ No ☐N/A
For example, LPA for health and welfare	
Verify you have seen original paperwork which has been registered and authorised ***by*** the Office of the Public Guardian ***and*** Attach copies to this document (if relevant)	☐ Yes ☐No ☐N/A
Is there a relevant Advanced Decision? Give further details below	☐Yes ☐No
Full name and Contact details of the Named Attorney/Deputy/Person with Parental responsibility	
Name and detail of any other person consulted:	
Name and detail of any other person consulted:	

Authorised decision makers will only be able to make decisions on matters covered by their LPA, EPA or Court order, although they should still be consulted when a best interest decision on other matters needs to be made. If you are not clear on the validity of the paperwork, then please contact the safeguarding team for further guidance.

If you are to proceed to a make Best Interests decision on the service user's behalf, you should consider at this stage whether or not an Independent Mental Capacity Advocate (IMCA) needs to be appointed. Staff must refer to the IMCA service if: - the person is un-befriended and there is a decision to provide, withdraw or withhold serious medical treatment; - there is to be a significant change in accommodation; - the person will stay in hospital longer than 28 days; -they will stay in the care home for more than eight weeks; - it is a situation where it is inappropriate or unsafe to consult family / friends (safeguarding concerns)

Independent Mental Capacity Advocate (IMCA) oes the person require an IMCA?	☐Yes ☐ No
Has a referral to the IMCA service been made?	☐ Yes ☐ No
Does the IMCA feel they need to be involved in the decision? If no, then please document the reason below:	☐Yes ☐ No
Full name and Contact details of the IMCA:	

This assessment is valid for the decision indicated at the time of completion.
Signature of assessor: **Date:**

Print full Name of assessor:

PLEASE ENSURE THIS ASSESSMENT IS KEPT IN THE PATIENT'S RECORDS

APPENDIX 2: BEST INTEREST DECISION MAKING TEMPLATE

Best Interest Decision Making Form

A best interest decision can only be made once a service user has been deemed to lack capacity for a specific decision. If a person has been formally assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in the service user's best interests.

If there is not an up-to-date Mental Capacity Assessment to evidence the person lacks the capacity to make the decision required, then the best interest assessment must not proceed until completed.

This form relates for person aged 16 years of age and over and has been developed to support your compliance with the Mental Capacity Act 2005. For more information please refer to the mental capacity policy, the Mental Capacity Act (MCA) Code of Practice - MCA Code of Practice or speak to the Designated Nurses for Safeguarding.

A best interest meeting is not a statutory requirement. In many cases, alternative consultation methods e.g., email or telephone is likely to be more appropriate and time efficient and discussions can be documented on this form

Remember the service user should be given every opportunity to be involved in the process

Full name of Service user:	
Date of Birth:	
NHS Number:	
Present Address/Location:	
Home Address (if different):	

The decision maker is usually the person who would be responsible for making the decision if the service user lacks mental capacity to make it for themselves.
In some instances, it might be appropriate for the best interest decision to be made jointly by, for example, a multi-disciplinary team. It is important to consider if there is someone, or something, already in place that might have the legal power to make the decision.

If the service user is unable to make the decision themselves, is there someone with a Registered Lasting Power of Attorney Health and Welfare (Enduring Power of Attorney under previous legislation), a Court appointed Deputy, or person with parental responsibility (if person is under 18 years of age) with powers to make the decision which needs to be made? Is there a valid Advanced Decision to Refuse Treatment (ADRT)? Or does the person require an Independent Mental Capacity Advocate (IMCA)?

Authorised decision makers will only be able to make decisions on matters covered by their LPA, EPA, ADRT or Court order, although they should still be consulted when a best interest decision on other matters needs to be made. Any authorised decision maker should be named on the mental capacity assessment prior to this assessment.

Name of Assessor:
Job title / role:
Work address and telephone number:
Date and time of assessment:

Best Interest Checklist

Please read the following statements prior to commencing the best interest meeting to ensure the following points are considered	
1	Can the decision be delayed in case the person regains the ability to make the decision in the future, for example, as a result of recovering from an episode or illness, learning new skills, or getting support with communicating their wishes?
2	The law says that when someone is working out what is in the best interests of another person, they cannot make a decision based merely on their appearance, age, medical condition, or behaviour.
2	When deciding what would be in their best interests all the relevant information needs to be considered, and it is important to involve the person as much as possible in decisions affecting them.
3	Consider the Person's wishes, feelings, values and beliefs. This includes any views they may have expressed in the past that would help to understand what their wishes and feelings might be. This may be things they have said to other people, how they have behaved in similar circumstances in the past and especially things they have written down. This places them at the centre of any decision being made on their behalf.
4	The views of their family members, parents, carers and other relevant people who support them or are interested in their welfare are sought, if this is practical and appropriate. If they have named someone particular or given someone powers to decide for them then they should be consulted.
5	If decisions are being made about treatment that is needed to keep them alive, people are not allowed to be motivated by a desire to bring about their death, and they must not make assumptions about the quality of their life.

Section 1: The decision to be made

The decision maker needs to clarify and document the decision to be made. It needs to be as specific and accurate as you can. 1. A best interest's decision can only be made once the service user has been assessed to lack capacity for that decision 2. The decision should be delayed wherever appropriate – e.g., if it is likely the service user will regain capacity or if their capacity is fluctuating It is also important to clarify that the decision is one that can be made under the Mental Capacity Act (2005). The MCA covers a vast range of health and social care decisions, but some decisions are specifically excluded. These are: Decisions concerning personal relationships – including marriage/civil partnership, divorce, sexual relations, adoption, voting and unlawful killing or assisted suicide. Should issues arise in relation to any of these decisions, the decision maker may wish to seek advice from the ICB Designated and Named Professionals.

Describe the decision that the person is making and why is it being proposed:
When describing the decision that needs to be made you need to be as specific and accurate as you can, and the less restrictive option should always be considered first.

Section 2: Service user involvement

What are the views, feelings, beliefs and wishes of the service user?
All practicable steps must be taken to assist the person concerns express their views, beliefs, wishes and feelings
What steps have been taken to help the service user attend and/or be involved with the best interest decision making process today and to be involved in the decision-making process (to support them in making the decision) themselves?
Explain below what steps have been taken (and if appropriate, why these attempts have failed)

Section 3: People consulted as part of the best interest decision making process

The best interest decision making process is to ascertain the wishes of the service user and take into account the views of others. There is a legal duty to take into account the wishes and views of family and relatives in the best interest decision making process. However, it is important for families and relatives to know the term "next of kin" now affords no legal authority to make decisions on behalf of another person.

Please give details of anyone engaged in caring for the person or interested in their welfare who has assisted with the decision to be made or anyone named by the service user to be consulted.

This could be family members, a close friend, neighbour, carers, social worker, and a court appointed deputy, someone with Lasting Power of Attorney for health and welfare and other professionals.

Name:	**Views:**
Role/relationship to the person:	
Contact details:	

Name:	**Views:**
Role/relationship to the person:	
Contact details:	

Name:	Views:
Role/relationship to the person:	
Contact details:	

Additional names/views if required:	

Section 4: Independent Mental Capacity Advocate (IMCA) involvement

An IMCA (Independent Mental Capacity Advocate) must be appointed If the service user has no friends or family who it would be appropriate to consult as part of the decision-making process and the decision is about:

- Serious medical treatment - practitioner who is responsible for person's treatment to consider the implications of the proposal and decide if consequences are serious for the individual. These may include starting, stopping or withholding treatment. Examples can range from blood tests, vaccinations, surgery, PEG insertion and DNACPR.
- NHS arranges hospital stay for 28 days or more.
- An accommodation moves for 8 weeks, or more is arranged.
- Safeguarding concerns or where there is a risk to involve family or friends in the safeguarding process
- Person requires restrictions which amount to a Deprivation of Liberty/ Liberty of Protection Safeguard (including meeting the Acid test criteria).

An IMCA cannot be involved when:

- the person has capacity to make the decision themselves
- the person who lacks capacity has previously named a person that should be consulted about decisions that affect them and that person is willing to help
- the person that lacks capacity has a court appointed deputy or attorney
- it is an emergency situation

If there has been an instruction of an IMCA please detail and involvement and views below.

IMCA Name and contact details:	
IMCA views and feelings:	

Section 5: Information gathering

Please discuss **all** the options available to the service user and list the information obtained in relation to: • The service users past and/or present wishes or feelings which relate to the decision • The service users' values and/or beliefs that relate to the decision (including cultural or religious considerations) • Any other factors that the service user would want to be considered as part of the decision-making process • Benefits and Burdens • All known risks identified • Probability and severity considered • Positive risks If there are more than 3 options, please add in another box

Please discuss and document option 1 2 examples below -Person to be placed in care home -Person needs admission to hospital for IV antibiotics	What is option 1:
Option 1 Benefits	**Option 1 Burdens**
Please discuss and document option 2 2 examples below: -Person stays in their own home with family support -Person stays at home and has oral antibiotics	What is option 2:
Option 2 Benefits	**Option 2 Burdens**
Please discuss and document option 3 2 examples below -Person stays in own home with 24-hour care -Person stays at home and has IV team coming in to give IV antibiotics	What is option 3:
Option 3 Benefits	**Option 3 Burdens**

Section 6: Best Interest Decision made after consideration of all the relevant factors

What best interest decision has been reached for the person?	

If there is an objection, who is objecting and what is the nature of the objection?	
What steps have been taken to resolve the objection?	

Disagreement: If there is disagreement consider the options outlined in the code of practice:

- Involve an advocate (IMCA)
- Get a second opinion or attempt some form of mediation
- Pursue a complaint through the organisation's formal procedures
- Approach the Court of Protection for a decision where all other attempts to resolve the disagreement have failed

Consider if the decision made could be a Deprivation of Liberty/Liberty of Protection Safeguard and seek further advice from the local authority DoLS team

Does there need to be a review of the decision?	☐ Yes ☐ No
What are the reasons for the review?	
Date of planned review:	

Section 7: Communication

Where the court is not involved, carers, relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances.

How is the decision going to be fed back to the service user and others involved?

The undersigned believe this to be a fair representation of the discussions that took place. We have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

This best interest decision is valid for the decision indicated at the time of completion.

Signature of decision maker: **Date:**

Print full Name of decision maker:

PLEASE ENSURE THIS ASSESSMENT IS KEPT OR SCANNED IN THE PATIENTS' RECORDS

APPENDIX 3: CONSENT TO SCREENING AND ASSESSMENT FOR NHS CONTINUING HEALTHCARE AND FUNDED NURSING CARE

Person's name:	NHS No:

Under the terms of the 2005 Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity.

1A) Person has capacity - If a person has capacity, only they can consent:			
I have received verbal / written information on the Continuing Healthcare assessment process, and I am aware that I can withdraw consent at any time. Date consent withdrawn:			
I have been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy, and that I have the right to decline any subsequent offer of care.			
I consent to an NHS Continuing Healthcare Checklist / Fast Track / Decision Support Tool and any subsequent reviews being undertaken.			
I consent to relevant information being gathered, collated and shared, where necessary and relevant, both as part of the ICBNHS Continuing Care process and as part of any subsequent dispute, including Independent Review Panel and Parliamentary and Health Service Ombudsman (PHSO).			
I have been informed that NHS Continuing Healthcare eligibility, including Fast Track, is subject to on-going review and is not indefinite.			
I would like the following person / representative involved in the assessment: **Name:** **Relationship:** **Contact Number:**			
Signature of Patient:			**Date:**
Print Name:			
1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:			
Signature:	**Name:**	**Designation / relationship:**	**Date:**

1C) Person has capacity - Consent to share and protect your personal information	
I agree that the information provided in this assessment may be shared with health and social care staff, service providers or brokers who contribute to or provide my care and any agencies acting on behalf of these organisations for the purpose / process relating to NHS Continuing Healthcare.	
I understand that this information will be used in the assessment of my eligibility for NHS continuing healthcare funding and may be used and shared with providers of care and brokers for the purpose of commissioning and or providing or a service, or care to me.	
I understand that I may withdraw my consent to share information at any time.	
I understand that I have the right to restrict what information may be shared and with whom but that this may affect the provision of care to me. **I have made the following restrictions (if applicable):**	
I understand that my information will be held on paper and on computer in accordance with the Data Protection Act 1998.	
Signature:	**Date:**
Print Name:	**Date:**
1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:	

Signature:	**Name:**	**Designation / relationship:**	**Date:**

If the person does not have the capacity to consent, then a 'Best Interest' decision will need to be made. Please proceed to complete the Best Interest part of the form

2) Best Interest Consent to Screening and Assessment for NHS Continuing Healthcare / Funded Nursing Care for People who lack capacity

2A) Best Interests Checklist	**Yes**	**No**
I have made every possible attempt to permit / encourage the person to take part in the assessment process		
I have tried to identify all the things that the person would take into account if they were making the decision or acting for themselves.		
I have tried to find out the views of the person who lacks capacity, including past / present wishes and feelings, any beliefs and values and any other factors that the person themselves would be likely to consider if they were making the decision or acting for themselves.		

I confirm that I have not made assumptions about their best interests on the basis of the person's age, appearance, condition or behaviour.		
I have considered whether the person is likely to regain capacity. • If yes, can the decision wait until then? • If no is the person likely to regain capacity? • If yes, can the decision wait until then? • If no continue with the Best Interest Assessment		
If it is practical and appropriate to do so, consult other people for their views about the person's best interests. This may include: • Any individual appointed under a lasting power of attorney • Any deputy appointed by the Court of Protection • Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues • Anyone engaged in caring for the person • Close relatives, friends or others who take an interest in the person's welfare • An Independent Mental Capacity Advocate (IMCA)		
Where the patient has nobody to act for them, other than paid carers, and a decision concerns serious medical treatment or a change in living arrangements (NHS accommodation for 28 days or more or Local Authority / Care Home accommodation for 8 weeks or more) then a referral must be made to an IMCA.		
Date of referral: Made by:		

2B) Other people Consulted (where applicable)			
Name:	Designation	Name	Designation
Name:	Designation	Name	Designation

Taking all of the above information into account, I confirm that proceeding with the assessment process is in the best interests of:

Name of patient:

OR

I am the attorney appointed under a Lasting Power of Attorney - **Welfare** made by the person / deputy appointed by the Court of Protection and agree on the patient's behalf.
A copy of the LPA or Court of Protection must be provided with this form.

NB: Lasting Power of Attorney (LPA) must have the power / scope to act in the circumstances and the LPA must be registered with the Office of the Public Guardian

I have received written information on the Continuing Healthcare Process.	

I have been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy and that I have the right to decline any subsequent offer of care.	
I confirm that it is in the best interests of (person's name)………………………….. to an NHS Continuing Healthcare Checklist / Fast Track/Decision Support Tool and all subsequent reviews being undertaken.	
I confirm that it is in the best interests of (person's name) ……………………………. that the information provided in this assessment be shared with health and social care staff, service providers / brokers and any agencies acting on behalf of these organisations for the purpose / process relating to NHS Continuing Healthcare and commissioning or providing care or a service to the patient. This could include the ICB and NHS England Independent Review Panel (IRP) or Parliamentary and Health Service Ombudsman (PHSO) for the purpose of dispute resolution or complaint handling.	

Signature:	**Date:**
Print Name:	**Designation:**
Relationship:	

APPENDIX 4: MENTAL CAPACITY FLOW CHART