|  |  |
| --- | --- |
| Humber and North Yorkshire Integrated Care Board logo | North East Lincolnshire Council logo |

|  |  |
| --- | --- |
| Internal ref: | MCA/ DoL NELC/ ICB (NEL) |
| Review date | March 2024 |
| Version No. | 3.3 |

**Mental Capacity Act 2005 and**

**Deprivation of Liberty**

**Policy**

**North East Lincolnshire**

**Council and NHS Humber and North Yorkshire Integrated Care Board (North East Lincolnshire Place) rights-based approach to supporting and empowering the vulnerable**

|  |  |
| --- | --- |
| Document Title: | Mental Capacity Act 2005 and Deprivation of Liberty Policy |
| **Version No:** | 3.3 |
| **Latest version issued:** | April 2024 |
| **Supersedes:** | All previous policies relating to the Mental Capacity Act 2005 and deprivation of liberty |
| **Name of Author (s):** | Emma Overton |
| **Consultation:** | North East Lincolnshire Clinical Commissioning Group (CCG) Equality Panel  (October 2017)  MCA Group (formerly Strategic Network)  (initially December 2018; subsequently March and May 2021; January, March and May 2023)  Safeguarding Adults Board February and April 2023  Children’s services representatives  (initially December 2018; September 2021) |
| **Approved by:** | Initially CCG Clinical Governance Committee; subsequently Care Contracting Committee/ Health and Care Contracting Group (HCCG)  Initially NELC Cabinet; subsequently portfolio holders for adult and children’s services |
| **Approval date:** | CCG February 2019; subsequently June 2021. HCCG 07 06 2023  NELC February 2019; subsequently March/ May 2021; May 2023 (portfolio holder for adults), November 2021 (portfolio holder for children) |
| **Review date:** | March 2024 |
| **Equality Impact Assessment Date:** | Reviewed March 2021 and May 2023 |
| **Target Audience:** | All staff commissioning or delivering care and treatment to individuals over 16 for whom NELC and/or Humber and North Yorkshire Integrated Care Board at Place (ICB) is responsible by statute or as agent. |
| **Dissemination:** | CCG website and Global newsletter, GP bulletin and provider newsletter. Each commissioner (Partner) and care and treatment provider (Care Delivery Partner) is responsible for disseminating this policy amongst its own relevant staff. |

|  |  |  |
| --- | --- | --- |
| Version | Description of Amendments | Date |
| 1.0 | Full policy review - new CCG policy |  |
| 1.2 | Addressing changes in case law | April 2016 |
| 1.3 | Annual review – no further changes – review date updated | September 2016 |
| 2.0 | Full policy update and revision by reference to changes to law and practice | January 2017 |
| 2.1 | Modest policy update/revision by reference to changes in practice/ case law clarifications | January 2018 |
| 2.2 | Modest policy update/revision by reference to changes in practice/ case law clarifications | January 2020 |
| 3.0 | Full policy update and revision by reference to changes to law and practice | June 2021 |
| 3.1 | Modest policy update/revision largely in respect of updating weblinks | March 2022 |
| 3.2 | Addition of guidance on adult refusals of care and treatment | April 2022 |
| 3.3 | Changes required due to NHS reorganisation (cessation of CCGs and creation of Integrated Care Boards (ICBs)). Clarification of requirements re reliance on statutory presumption of capacity, plus importance of specifying the information relevant to the decision against which capacity is assessed. | April 2023 |

[1 Introduction 3](#_Toc136937518)

[2 Scope and definitions 3](#_Toc136937519)

[3 Policy purpose and key considerations 4](#_Toc136937520)

[3.1 Purpose 4](#_Toc136937521)

[3.1.1 Achieving the vision for Place 4](#_Toc136937522)

[3.1.2 Legal compliance and assurance 4](#_Toc136937523)

[3.2 key considerations 5](#_Toc136937524)

[3.2.1 the European Convention on Human Rights (ECHR) 5](#_Toc136937525)

[3.2.2 United Nations Convention on Rights of Persons with Disabilities 2006 (CRPD) 6](#_Toc136937526)

[3.2.3 Human Rights Act 1998 (HRA) 6](#_Toc136937527)

[3.2.4 Mental Capacity Act 2005 (MCA) 7](#_Toc136937528)

[3.2.5 Equality Act 2010 (EqA) 9](#_Toc136937529)

[3.2.6 NHS Constitution 9](#_Toc136937530)

[4 Policy 10](#_Toc136937531)

[4.1 Principle One: proactive considerations of capacity 11](#_Toc136937532)

[4.2 Principle Two: supported decision making and identifying the decision maker 12](#_Toc136937533)

[4.2.1 advocacy and supported decision making 12](#_Toc136937534)

[4.2.2 identifying the decision maker 13](#_Toc136937535)

[4.2.2.1 The process for identifying decision makers: a summary 13](#_Toc136937536)

[4.2.2.2 the process for identifying decision makers: more detailed considerations 14](#_Toc136937537)

[4.3 Principle Three: unwise decisions, incapacitous refusals of care and the role of others in individuals’ accessing care 16](#_Toc136937538)

[4.3.1 incapacitous refusals of necessary care 17](#_Toc136937539)

[4.3.1.1 known refusers of necessary care 17](#_Toc136937540)

[4.3.1.2 administration of necessary medication without consent 18](#_Toc136937541)

[4.3.2 the role of others in individuals accessing care 18](#_Toc136937542)

[4.3.2.1 obstructing access to necessary care/ treatment 18](#_Toc136937543)

[4.3.2.2 the inherent jurisdiction of the High Court 19](#_Toc136937544)

[4.4 Principle four: best interests decision making 19](#_Toc136937545)

[4.5 Principle five: less restrictive practice 21](#_Toc136937546)

[4.5.1 Deprivation of Liberty 21](#_Toc136937547)

[5 Training 22](#_Toc136937548)

[6 Impact analysis 23](#_Toc136937549)

[6.1 Equality 23](#_Toc136937550)

[6.2 Bribery Act 2010 23](#_Toc136937551)

[7 Implementation 24](#_Toc136937552)

[8 Monitoring and review 24](#_Toc136937553)

[9 References and links to other documents 24](#_Toc136937554)

[9.1 references 24](#_Toc136937555)

[9.2 useful links 25](#_Toc136937556)

[APPENDIX A: Yorkshire and the Humber Mental Capacity Act Network 26](#_Toc136937557)

[GUIDANCE: REPORTING DEPRIVATION OF LIBERTY RELATED SAFEGUARDING CONCERNS 26](#_Toc136937558)

[APPENDIX B: Triggers and Responses 28](#_Toc136937559)

[APPENDIX C – Proactively Recording Capacity (practice note) 33](#_Toc136937560)

[APPENDIX D – Capacity Assessment Tools 34](#_Toc136937561)

[APPENDIX E – Best Interests Decision Guidance and Tools 35](#_Toc136937562)

[APPENDIX F – Recording a Best Interest Decision made by a Relevant Attorney or Court of Protection Deputy 40](#_Toc136937563)

[APPENDIX G - Prescription and Administration of Medication without Consent 42](#_Toc136937564)

[APPENDIX H – practice guidance on Adult Refusals of Care and Treatment 43](#_Toc136937565)

[APPENDIX I - MCA Commissioning Standards 44](#_Toc136937566)

## 1 Introduction

This policy is owned by the NHS Integrated Care Board (ICB) North East Lincolnshire Place and North East Lincolnshire Council (NELC). It sets out local expectations regarding application of the Mental Capacity Act 2005 (MCA). The policy is intended to foster a rights-based approach to supporting and empowering the vulnerable in circumstances where they may lack capacity to make decisions for themselves.

This policy should be read in conjunction with North East Lincolnshire Place safeguarding policies and procedures, which can be found at <https://www.safernel.co.uk/> . Regional guidance on reporting deprivation of liberty related safeguarding concerns also appears at Appendix A. To recognise the clear link between the MCA and safeguarding, the North East Lincolnshire Safeguarding Adults Board provides oversight and challenge for implementation of the MCA.

Via an agreement under s75 of the National Health Service Act 2006, NELC delegated some adult social care responsibilities to the ICB, and the ICB delegated some children’s health functions to NELC.  NELC and the ICB (the Partners) commission a number of providers (Care Delivery Partners) to deliver health and social care functions; each Partner commissions such functions on its own behalf, and on behalf of the other Partner, acting as delegate. In addition to commissioning care and treatment, both Partners deliver some services and support (the ICB delivers NHS Continuing Healthcare (CHC) and NELC delivers a range of health functions for children and social care functions for children and young adults up to the age of 25).

Whilst NELC retains statutory responsibility for functions under the MCA which it has partly delegated to the ICB (most notably acting as supervisory body under the Deprivation of Liberty Safeguards - DoLS), local arrangements for authorising deprivations are managed jointly by the Partners, with the DoLS Team at Focus Independent Adult Social Work (Focus).

This policy has been revised by a task and finish group comprising representatives from the ICB and key Care Delivery Partners: Care Plus Group (CPG), Focus, Navigo and Northern Lincolnshire and Goole Hospital Trust (NLaG).

## 2 Scope and definitions

This policy applies to all staff employed or contracted by the Partners and Care Delivery Partners, including North East Lincolnshire’s GP practices and all practice staff. This policy is applicable to the commissioning or delivery of care and treatment for/ to individuals over 16 for whom NELC and/ or the ICB is responsible by statute or as agent. The needs of those under 16 are not referenced in this policy.

In this policy, the following terms have the meanings given below:

* ‘individual’ means those of 16 years of age and over
* ‘adult’ means those of 18 years of age and over
* ‘staff’ means all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students, apprentices and any other others undertaking any type of work experience or work related activity
* ‘care practitioner’ means staff directly interfacing with members of the public: individuals with needs, carers, families and representatives
* ‘care and treatment’ means the provision of services, support or other activity to individuals in need of social care or healthcare (including mental healthcare), and carers in need of support
* consent means agreement to care and treatment which is:
* voluntary (not coerced)
* informed (regarding the nature of the care/ treatment proposed, why it is proposed, and the reasonably foreseeable consequences of proceeding or not proceeding with the care/ treatment)
* and capacitous (within the meaning of the MCA)

All care and treatment must start with care practitioners seeking the consent of the individual they are working with (e.g. patient or service user). Where such consent cannot be secured because that individual lacks relevant capacity, the MCA sets out the framework by which care/ treatment may be given lawfully.

All references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching to them.

## 3 Policy purpose and key considerations

## 3.1 Purpose

## 3.1.1 Achieving the vision for Place

This policy forms a part of the Partners’ plans to deliver a shared vision for the people of North East Lincolnshire. The Integrated Care Strategy for North East Lincolnshire sets out an ambition for ‘everyone in our population to live longer, healthier lives’. Similarly, the Council Plan sets out an intention for North East Lincolnshire to be a place “where citizens of all ages live active, healthy and independent lives”. The Council Plan reiterates the vision for adults described in the Adult Strategy 2019 - 2022 (“all adults in North East Lincolnshire will have healthy and independent lives with easy access to joined up advice and support, helping them to help themselves”).

Delivering this vision means:

* working with adults in a way that is person-centred, fair and compassionate, to proactively help them to understand their choices, and positively promote the ability to make their own decisions
* that care and treatment is delivered by a legally literate workforce, able to champion rights-based care.

The Partners view application of the MCA - and therefore this policy – as a crucial and fundamental aspect of delivering this vision.

## 3.1.2 Legal compliance and assurance

A further purpose of this policy is to ensure that no act or omission by the Partners and/ or their Care Delivery Partners is in breach of the MCA. A breach of the MCA may lead to civil or criminal liability. Where either NELC or the ICB acts as the lead commissioner of care or treatment, it will notify other commissioners of a Care Delivery Partner’s non-compliance with the MCA or any serious untoward incident that relates to mental capacity.

Care Delivery Partners must provide the Partners with assurance that their responsibilities under the MCA are discharged lawfully. Each Partner and Care Delivery Partner will provide evidence of and ensure that:

* + Operational procedures are in place to ensure that all relevant staff act in compliance with the MCA and this policy
  + Operational procedures are in place to ensure that all relevant staff take opportunities to actively promote planning and advance decision making for individuals
  + All relevant staff are aware of their responsibilities with respect to the MCA, and understand when and how to apply it
  + An MCA training plan with detailed programme of delivery is in place, regularly reviewed, and amended where required to take account of change to law and practice
  + All relevant staff undertake MCA training commensurate with their role, and as a minimum, in line with the National Mental Capacity Forum’s MCA Competency Framework, and continue to maintain their knowledge of, and ability to apply, the MCA
  + All relevant staff support delivery of MCA compliant practice by appropriately applying principles of confidentiality and information sharing
  + Lines of accountability and corporate responsibility for MCA matters are clear, and appropriate governance arrangements are in place to deliver best MCA practice
  + Non-compliant MCA practice is proactively identified and challenged both corporately and by staff individually, to secure individual and collective ownership of the MCA
  + Regular audits are undertaken to identify and address areas of weak MCA practice. Where such areas are identified, an action plan is created to ensure delivery of improvements to practice within a reasonable timeframe
  + Where contracting with others for relevant services, contracts specify compliance with the MCA; such contracts are supported and monitored for compliance with the MCA.

To support delivery and monitoring of this policy, all care practitioners are asked to lodge generic MCA, and DoLS, concerns on the portal at <https://incidents.northeastlincolnshireccg.nhs.uk/> or via [hnyicb-nel.askus@nhs.net](mailto:nelccg.askus@nhs.net) .

## 3.2 key considerations

## 3.2.1 the European Convention on Human Rights (ECHR)

The ECHR is an international treaty designed to protect human rights and fundamental freedoms; rights are listed in the form of Articles and Protocols. The ECHR established the European Court of Human Rights (ECtHR), which allows anyone who feels their convention rights have been violated by a signatory state to take their case to the ECtHR. Judgements of the ECtHR are binding on the states concerned, and provide guidance to all signatory states. Care practitioners are expected to gain and maintain a familiarity with the ECHR and the judgements of the ECtHR applicable to their area of professional practice.

Three ECHR Articles are of particular relevance to this policy:

* Article 1: imposes an obligation on contracting states to secure to everyone in their jurisdiction the rights and freedoms defined in the ECHR, and so creates rights against the state where such obligations are not met
* Article 5: provides that “everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in [specified] cases and in accordance with a procedure prescribed by law”. Specified cases include detention of persons of “unsound mind” for the purpose of receiving care or treatment. Everyone deprived of liberty, is entitled to take proceedings by which the lawfulness of their detention is decided speedily by a court, and their release ordered if the detention is not lawful. Article 5 aims to avoid arbitrary detention
* Article 8: protects an individual’s right to private and family life, which extends to rights of physical and psychological integrity. An individual’s right to refuse medical treatment falls within the scope of Article 8. Any deprivation of liberty for the purpose of delivering care/ treatment will limit private and family life, although a person deprived of liberty continues to enjoy all the other rights and freedoms guaranteed by the ECHR.

## 3.2.2 United Nations Convention on Rights of Persons with Disabilities 2006 (CRPD)

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, and to promote respect for their inherent dignity. ‘Persons with disabilities’ includes those who have long-term mental or intellectual impairments which may hinder their full and effective participation in society. There are eight guiding principles that underlie the CRPD. The principles of the CRPD are taken into account by the ECtHR in its interpretation of rights under the ECHR. Of particular relevance to this policy is the principle of non-discrimination, which requires that ‘reasonable accommodations’ be made for those with disabilities; these are ‘necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden […] to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms’. The requirement to make ‘reasonable accommodations’ to ensure equal enjoyment of rights links with the MCA’s second principle (which requires ‘all practicable steps’ to be taken to support individuals to make their own decisions).

The CPRD sets out requirements across a number of articles. Whilst a number of the articles are particularly pertinent to this policy, the Partners particularly wish to highlight the importance of Article 19, regarding independent living and community inclusion. Careful application of the MCA will serve to promote the inclusion and participation of those who may lack decision making capacity. This means not only supporting adults to record their capacitous choices whilst they have the ability to do so, but also supporting those with some level of incapacity to make their own choices wherever possible. Promoting the CRPD’s notion of equality of choice is an important part of best interests decision making within the MCA’s s4 framework. In so far as decision making under the MCA focuses on identifying the wishes and feelings of the incapacitous individual, with the objective of reasserting that individual’s right to make his/ her own decisions in the way they would have done had they not lost capacity, the MCA is reflective of the CRPD’s ethos.

## 3.2.3 Human Rights Act 1998 (HRA)

The HRA gives effect to the rights and freedoms guaranteed under the ECHR by making such rights enforceable under domestic law. The HRA declares that it is unlawful for a public authority to act in a way which is incompatible with the ECHR (NB the definition of ‘public authority’ includes anyone performing a public function; s73 of the Care Act 2014 states that provision of regulated care and support is a public function). Interference with rights under the ECHR must not be arbitrary or excessive, but must be necessary and proportionate to the legitimate aim pursued.

## 3.2.4 Mental Capacity Act 2005 (MCA)

The MCA provides a statutory framework to empower and protect vulnerable people who lack capacity to make their own decisions. The framework covers a wide range of decisions on personal welfare and financial matters. The MCA sets out who can make decisions with and for vulnerable people, in which situations, and how they should do so. The MCA also enables people to plan ahead for a time when they may lose capacity to make decisions. The MCA provides recourse, where necessary, to a court with power to deal with all personal welfare and financial decisions on behalf of individuals lacking capacity.

A care practitioner providing care or treatment for an individual will be protected from liability only if (as a first step) they take ‘reasonable steps’ to establish that the individual lacks capacity in relation to the matter in question, and when providing care and treatment they reasonably believe (backed by objective reasons) that the individual lacks capacity and that it is in their best interests to receive it. What constitutes ‘reasonable steps’ will depend on the circumstances: the more serious the decision, the more formal the assessment of capacity required. Broadly, the care practitioner proposing the care and treatment is responsible for ensuring an appropriate assessment of capacity; it is for the practitioner to consider whether they have reasonable grounds to believe the individual lacks capacity to consent to the care and treatment, and whether they are thus in a position to proceed on a best interests’ basis.

The MCA introduced two criminal offences which apply to anyone caring for an individual who may lack capacity, an attorney under Lasting Power of Attorney or Enduring Power of Attorney, and a Court of Protection (CoP) appointed deputy. The offences carry a range of penalties from a fine to a prison sentence of up to five years or both. The offences are:

1. Ill treatment of an individual who lacks capacity to make relevant decisions; a person will be guilty of ill treatment if they have either deliberately ill-treated someone or been reckless in the way they treated that individual, with disregard for harm or damage to the individual’s health
2. Wilful neglect of an individual who lacks capacity to make relevant decisions; commission of the offence is dependent on the circumstances, but usually arises where a person has deliberately failed to carry out an act they knew they had a duty to carry out.

The majority of the provisions in the MCA apply to individuals of 16 years and over who may lack capacity to make specific decisions (excepting the Deprivation of Liberty Safeguards and the creation of statutory Wills, Lasting Powers of Attorney and Advance Decisions to Refuse Treatment). Matters concerned with the care and welfare of children and young people are resolved largely by reference to the Children Act 1989 and the common law (judge-made law). The MCA applies to children under 16 years in two ways:

* The CoP can make decisions about the property and affairs of a child where it is likely that the child will lack capacity to make those decisions once 18
* The criminal offences of ill treatment and neglect apply regardless of the victim’s age.

Deprivation of Liberty Safeguards (DoLS) and Deprivations of Liberty

The DoLS are contained in the MCA; they aim to ensure that adults (the DoLS apply only to those of 18 years of age and above) lacking capacity to consent to being accommodated in a hospital or care home to receive care and treatment are only deprived of liberty in their best interests. The DoLS offer a process for authorising a deprivation of liberty and a means to challenge such deprivation. The DoLS require a hospital or a care home to apply to the ‘supervisory body’ for authorisation of a deprivation of liberty on its premises. The supervisory body is usually the local authority for the place where the adult is ordinarily resident.

The DoLS apply to hospitals (general and psychiatric) and care homes, collectively referred to as ‘standard settings’; they do not extend to supported living or domestic settings (‘non-standard settings’ or ‘community settings’). Applications to authorise deprivations in non-standard settings must be made to the CoP. The CoP has striven to create a process for non-standard authorisations which, as far as possible and appropriate, mirrors the DoLS process. The CoP’s jurisdiction to authorise deprivation of liberty of those lacking relevant mental capacity is available only from the age of 16; the inherent jurisdiction of the High Court is available regardless of age.

Deprivation of liberty under the MCA has the same meaning as in Article 5(1) ECHR. The ECtHR has defined a deprivation for the purposes of Article 5(1) as having 3 elements, all of which need to be satisfied before a particular set of circumstances will amount to a deprivation of liberty falling within the scope of Article 5:

1. the objective element of confinement in a particular restricted place for a non- negligible period of time
2. the subjective element of lack of valid consent to that confinement; and
3. the attribution of responsibility to the state.

The test for establishing the objective component of a deprivation was further defined by the UK Supreme Court in the Cheshire West case (*P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19*); the ‘acid test’ for a deprivation requires that the individual concerned is:

1. under continuous supervision and control and
2. not free to leave.

Where a 16 or 17 year old lacks capacity to give their own consent to circumstances satisfying the ‘acid test’ in Cheshire West, and the state either knows or ought to know of the circumstances, then the child is deprived of their liberty for the purposes of Article 5 and requires the protections afforded by that Article.  This is the case whether or not their parent(s) consent to the circumstances amounting to a deprivation of liberty imposed by others, or whether directly imposing those circumstances themselves.

Deprivation of liberty of those aged between 16 and 17 is not considered in detail in this policy; deprivation of liberty of those aged under 16 is not considered at all. Guidance on the issues in relation to authorisation of deprivation of liberty for those under 18 can be found at: <https://www.researchinpractice.org.uk/media/4753/joint_deprivation-of-liberty-and-young-people_web.pdf>. Deprivation of liberty for those under 18 is a rapidly changing area of law which those working with this age group will need to keep abreast of.

It should be noted a deprivation of liberty will generally not come within Article 5 where an individual:

* is receiving necessary life-saving medical treatment for physical illness
* which is unavoidable as a result of circumstances beyond the control of the authorities and
* their treatment is not materially different from that which would be administered to a person without mental impairment, but with the same physical illness.

A summary of the 2017 judgement in *‘Ferreira’*, which established when medical treatment cases will generally fall outside of Article 5, can be found at: <https://www.39essex.com/cop_cases/r-ferreira-v-hm-senior-coroner-inner-south-london-others/>

The Liberty Protection Safeguards (LPS) may replace DoLS and equivalent CoP processes in future. The LPS will trigger a revision of this Policy; in the interim they are referenced only minimally. To support the information sharing required to make LPS work effectively, the Partners have agreed that:

* providers of a commissioned care at home package or placement in residential care will be provided with the adult’s capacity assessment and best interest decision (relating to the package/ placement)
* where the documents need to be emailed, they will be shared via NHS mail only.

## 3.2.5 Equality Act 2010 (EqA)

Anti-discriminatory practice is a fundamental part of ensuring an ethical basis for care and treatment provision, and critical to the protection of individual dignity. The EqA protects those receiving care and treatment from unfair treatment on named grounds known as the ‘protected characteristics’. The protected characteristics are:

* + age
  + disability
  + gender reassignment
  + marriage and civil partnership
  + pregnancy and maternity
  + race (including ethnic or national origins, colour or nationality)
  + religion or belief (including lack of belief)
  + sex
  + sexual orientation.

Direct discrimination occurs when an individual is treated less favourably than another in similar circumstances on the grounds of a protected characteristic. Indirect discrimination occurs when a condition or requirement is applied equally to everyone but some are unable to comply because of a protected characteristic; this is unlawful unless the condition or requirement is objectively justifiable. The EqA also prohibits harassment and victimisation.

The EqA applies to all delivering public services; following the principles in the EqA will enable care practitioners to ensure that individuals receive care and treatment that is respectful, inclusive and effective, and that they are able to access help which meets their needs and takes into account any which may arise as a result of one or more protected characteristics. Case law has highlighted that the central ethos of the MCA and EqA are entirely consonant: “The MCA aims, ultimately, to promote equality for the incapacitous to the same degree as their capacitous coevals. It imposes an obligation actively to promote capacitous decision taking and it erects a presumption of capacity in order most effectively to promote personal autonomy” (Cumbria County Council v A [2020] EWCOP 38, para 33).

## 3.2.6 NHS Constitution

The aim of the Constitution is to safeguard the principles and values of the NHS. The ICB is required by law to take account of the Constitution in its decisions and actions. The ICB must, in the exercise of its functions, act with a view to securing health services that are provided in a way which promotes the Constitution, and promotes awareness of it.

The principles and values within the NHS Constitution are reflective of those within the MCA; for example principle four states that “the patient will be at the heart of everything the NHS does” and the value of respect and dignity states “we value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits’.

The rights and responsibilities in the Constitution generally apply to everyone who is entitled to receive NHS services, and to NHS employees. Whilst the Constitution may not be directly applicable to delivery of social care in local authorities in which such functions are not delegated, in North East Lincolnshire it is expected that the principles and values in the Constitution will apply to delivery of all care and treatment services commissioned by the Partners. Equally, whilst not all staff to whom this policy applies are employed by the NHS, each staff member is expected to consider how the Constitution’s principles/ values might apply within their own setting.

## 4 Policy

All care and treatment starts with care practitioners seeking the consent of the individual they are working with. Where such consent cannot be secured because that individual lacks relevant capacity, the MCA must be considered before care/ treatment can be delivered lawfully. Consent is the basis of all therapeutic relationships, and therefore MCA considerations should form a core part of everyday practice in health and care settings. To support such considerations, a generic ‘client journey’ across health and care has been envisaged, and a non-exhaustive list of essential considerations have been detailed at each stage of that journey (see Appendix B ‘Triggers and Responses’). Generic considerations applied to particular settings and complex circumstances have limitations, but provide a starting point; they are not intended to circumvent professional judgement.

This policy is intended to draw attention to *some* areas of the MCA of particular relevance to local practice; it does not include a fully comprehensive list of considerations. This policy should be read in tandem with the MCA Code of Practice (the Code) and DoLS Code of Practice (the DoLS Code). Care practitioners are also expected to remain familiar with guidance offered by up to date domestic and ECtHR case law.

**Application of the MCA’s Principles**

The MCA’s five principles should underpin all acts done and decisions taken in relation to those who lack, or may lack, capacity. The principles set out the values beneath the legal requirements; they are the basis of a strong rights-based practice designed to empower and protect individuals, and the care practitioners acting on their behalf.

The Five Principles (MCA, s1):

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his best interests
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

## 4.1 Principle One: proactive considerations of capacity

The presumption of capacity is fundamental: it has been described as “every bit as important as the presumption of innocence in a criminal trial” (London Borough of Tower Hamlets v PB [2020] EWCOP 34). The individual who may lack capacity does not have to ‘prove’ that they have it. The burden of proving lack of capacity to take a decision lies with the person who considers it necessary to take the decision on an individual’s behalf. It is the decision maker that needs to satisfy themselves of the individual’s capacity, ‘on the balance of probabilities’.

Mental capacity is decision-specific. The statement “Mrs Jones lacks capacity” is legally meaningless. Care practitioners must ask themselves “what is the decision that needs to be taken?”. If this question is not defined with precision, a capacity assessment will be pointless (because the assessment must relate to the decision).

The act of carrying out a mental capacity assessment can be intrusive; to assess an individual’s capacity is to interfere with their right to respect for private life under Article 8 ECHR. There must always be grounds to consider that an assessment is necessary. Conversely, care practitioners must be prepared to justify a decision not to carry out an assessment where there appear to be reasons to consider that the individual cannot take the relevant decision for themselves. Care practitioners must not hide behind the presumption of capacity to avoid responsibility for making an appropriate capacity assessment.

Where reliance on the statutory presumption of capacity is appropriate and further assessment is not required, care practitioners are expected to proactively evidence that such is their view. Proactively recording reliance on the statutory presumption is intended to evidence that capacity has been properly considered, and not simply overlooked. Standard forms used by care practitioners should include provisions enabling proactive recording of capacity; if they do not, the appendixes to this policy offer:

* suggested wording for proactive consideration of capacity (Appendix C)
* tools for recording a capacity assessment (Appendix D). Equivalents are available as a questionnaire on SystmOne.

Reliance on the statutory presumption, without further consideration, will not be appropriate where there is evidence or information known to the care practitioner, or reasonably available to them, which *could* indicate the *possibility* of incapacity. Evidence or information will include the care practitioner’s own observations of the individual, plus information available from the individual’s records and from those with experience of the individual such as their family members or other professionals. For example, whilst a diagnosis alone categorically does NOT justify automatic departure from the statutory presumption, where a care practitioner knows that the individual has a diagnosis which may impact on capacity, reliance on the statutory presumption without further careful consideration is unlikely to be adequate. Care practitioners are expected to record their considerations, even where further such consideration establishes that an in-depth, more formal capacity assessment is unnecessary. Any consideration of an individual’s ability to give consent or to make a decision is an assessment of sorts, which must be recorded. The nature and extent of the recording should be proportionate to the circumstances (taking into account the nature of the decision and its consequences). Where a finding of incapacity is likely, a formal record of the assessment is essential.

A range of capacity assessment tools are at Appendix D. Which tool is the most appropriate will depend upon the circumstances under which capacity is assessed; for example, an emergency assessment in an A&E setting of whether an apparently brain-injured patient has the capacity to run out of the ward into a busy road will not demand the same level of detail in the assessment (or its recording) as an assessment of whether a 90 year old woman has the capacity to decide to continue living in her home of 50 years where the concerns relate to her declining abilities to self-care. This example was given in 39 Essex Chambers’ guidance note on assessing and recording capacity; the most recent version of the guide can be found at <https://www.39essex.com/tag/mental-capacity-guidance-notes/> Via that same link, practitioners can also access guidance on fluctuating capacity, and on the types of information the court has identified as relevant when assessing capacity in respect of some specific decisions. Guidance is also available from <https://capacityguide.org.uk/> and SCiE at <https://www.scie.org.uk/mca/practice/assessing-capacity/>

A very useful guide to assessing capacity in respect of financial decisions, and identifying the information relevant to such decisions, can be found at: <https://empowermentmattersweb.files.wordpress.com/2014/09/assessing-capacity-financial-decisions-guidance-final.pdf> It is particularly helpful in offering guidance for supporting and empowering individuals with such decision making.

## 4.2 Principle Two: supported decision making and identifying the decision maker

It cannot be emphasised enough that all practicable steps must be taken to support an individual to take their own decisions. The involvement of individuals in the decisions which affect them is fundamental to participation in society, and to social inclusion. Supporting the individual to make their own decisions fosters self-determination and person-centred outcomes. Careful application of the MCA may enable some with borderline capacity to regain it. Whilst not always achievable, empowering individuals to make their own choices must be the goal of every care and treatment interaction in which it is practicable: for example, it may not be practicable to support an unconscious person in need of immediate treatment following a road accident to make a decision regarding such treatment; conversely, an elderly person considering their care options may appear to lack capacity, but with time to reflect on clear explanations, and the opportunity for discussion with family or an advocate, they may be enabled to make their own choice.

NICE guidance on decision making and mental capacity can be found at <https://www.nice.org.uk/guidance/qs194>. A supported decision-making toolkit is available at [SLT-SDM-Toolkit81.pdf (essex.ac.uk)](https://autonomy.essex.ac.uk/wp-content/uploads/2023/01/SLT-SDM-Toolkit81.pdf)

### 4.2.1 advocacy and supported decision making

Whilst consideration of advocacy most often arises *after* it has been established that an individual lacks capacity in relation to a relevant decision, consideration can be given to using an advocate to support an individual to make their own decision. The provisions of this section of the policy in relation to supported decision making apply equally to use of advocacy in best interests decision making, but will not be repeated.

Care practitioners must ensure they are familiar with statutory triggers for provision of advocacy arising via both the MCA and the Care Act 2014 (provision of advocacy under the Mental Health Act 1983 (MHA) is outside the scope of this policy). Some individuals will be entitled to advocacy under more than one piece of legislation. In summary, the statutory requirements most relevant to this policy are as follows:

* MCA advocacy must be provided where in respect of an individual who lacks relevant capacity, a decision needs to be made about either a long-term change in accommodation or serious medical treatment, and there is no one independent of services, such as a family member or friend, who is appropriate to consult. IMCAs must also be instructed for adults being assessed in relation to a deprivation of liberty, where there is no one appropriate to consult; for adults subject to a standard deprivation of liberty authorisation, IMCAs must be provided both to fill any gaps in appointments of an unpaid ‘relevant person’s representative’ (RPR), and if requested by the adult or their unpaid RPR where the supervisory body believes either could benefit from IMCA support
* Care Act advocacy must be provided where an adult has substantial difficulty in being involved in a social care process (e.g., care assessment), and does nothave an appropriate individual to support them in this.

A useful guide to advocacy under the MCA and Care Act – including the triggers for each - can be found here: <https://www.scie.org.uk/advocacy>

Where a statutory entitlement to advocacy does not arise, care practitioners should nevertheless ensure that prompt consideration is given to use of discretionary powers to appoint an advocate, particularly in cases where capacity and/ or best interests are disputed, and such appointment may avoid escalation of the dispute.

The Partners and Care Delivery Partners will have in place arrangements to ensure the appropriate referral of all individuals in need of an advocate to represent them and support their participation.

### 4.2.2 identifying the decision maker

### 4.2.2.1 The process for identifying decision makers: a summary

For as long as an individual has capacity to make their own choices, care and treatment decisions require their consent – they are the decision maker. If the adult lacks capacity to consent (or refuse) care and treatment, Advance Decisions to Refuse Treatment (ADRTs) must be acted on where valid and applicable. If there is no valid and applicable ADRT, consent must be sought from anyone appointed under the MCA to make such decisions on the individual’s behalf – an appointed decision maker.

Where there is no appointed decision maker, the person proposing the care and treatment is generally the decision maker, and they will need to consider whether reliance on the MCA’s s5 is appropriate (reference should also be made to s6) or a CoP application is necessary. Complexities may arise where:

* the practitioner carrying out the care/ treatment is acting on the direction or under the supervision of another, or subject to a plan drawn up by another. Here, the practitioner must still be satisfied that they are acting in the best interests of the individual before carrying out the act, even if relying on another’s views set out in the plan. For example, a hospital consultant who has devised an individual patient’s care plan may be thought of as the decision-maker, but a nurse enacting that plan must still be satisfied that their actions will meet the requirements of s5 (and s6, where relevant) if they are to secure its protection
* there are staff involved in the individual’s care from different organisations. Here it is important that there is one person who is identified as having the responsibility for the coordination of the best interests process, perhaps delegating some aspects of that process to staff with the right skills to ensure all the matters set out under the MCA are considered. For example, a GP decision maker may ask care home staff to collate necessary information to support a decision that vaccination is in an individual’s best interest, but the vaccinator must still be satisfied on the basis of that information that their actions will meet the requirements of s5 (and s6, where relevant) if they are to secure its protection.

In any event, it should be clear who holds accountability for making a decision. Where there is a best interests dispute between professionals, or doubt as to whether an attorney or deputy is acting in the person’s best interests reference must be made to the CoP (see further the 39 Essex Chambers’ Best Interests Assessments Guide, referenced below).

### 4.2.2.2 the process for identifying decision makers: more detailed considerations

The four main decision-making mechanisms under the MCA for incapacitous persons are considered below, in two categories. This two category approach is set out within the Court of Protection Handbook: a user’s guide (Ruck Keene, Edwards, Eldergill and Miles, second edition, 2017) as part of a useful overview of the MCA.

Category One: arrangements made by the adult whilst they had capacity

1. Lasting Powers of Attorney (LPAs): an adult with capacity to do so (the donor) may appoint trusted persons (attorneys) to make decisions for them. An attorney appointed under a health and welfare LPA has no authority to make personal welfare decisions which the donor has capacity to make for themselves; attorneys are only able to make such decisions after the donor has lost capacity to make the decision in question, and only in accordance with the terms of the LPA. A property and financial affairs LPA authorises attorneys to make decisions relating to the donor’s property and finances immediately following registration of the LPA with the Office of the Public Guardian (OPG), unless a restriction on the LPA prohibits this. LPAs for business are also available. LPAs replaced Enduring Powers of Attorney (EPAs); EPAs relate to property and finances only and do not authorise personal welfare decisions. Existing EPAs remain valid but new ones cannot be created
2. Advance Decision to Refuse Treatment (ADRT): an adult with capacity to do so may make an advance decision to refuse particular treatment at a later time at which they lack capacity to decide whether to accept/ refuse it. When an adult loses capacity to make the particular treatment decision, the ADRT is binding where it is valid and applicable i.e.:

* It is clear and unambiguous
* It is written when the adult had sufficient mental capacity and had been fully informed about the consequences of refusal of treatment, including the fact that it may hasten death
* It has not been drawn up under the influence of others
* It has not been withdrawn by the adult whilst capacitous, and the adult has not done anything else clearly incompatible with the ADRT remaining their fixed decision
* It is relevant to the medical treatment/ circumstances and intended to apply in the situation which has arisen
* There are no reasonable grounds to believe that circumstances now exist which the adult did not anticipate at the time of creating the ADRT which would have affected their decision
* If relating to life-sustaining treatment, is in writing, signed and witnessed, and includes a statement that it is intended to apply even if life is at risk.

When considering making decisions on behalf of an incapacitous adult, care practitioners must first check whether, when they had capacity to do so, the adult made their own arrangements to cater for the situation in hand (as at category one a) and b), above). If they did make such arrangements, then unless the documents seeking to give effect to them are invalid or not applicable for sound legal reasons, the arrangements apply. In other words, where an attorney has been appointed to make the decision in question, that attorney is the decision maker. Similarly, where an ADRT is valid and applicable, the incapacitous adult has in effect, already made their own decision. However, care practitioners must ensure that they:

* seek a copy of the document granting decision making authority (i.e. the LPA or EPA) and/ or refusing treatment (i.e. the ADRT) and retain a copy with the adult’s records, for future reference
* check that the document is registered with the OPG, where necessary. ADRTs do not require registration. LPAs cannot be used until registered; EPAs do not need to be registered unless “the attorney has reason to believe that the donor is or is becoming mentally incapable” (MCA schedule 4, paragraph 4). Whether the LPA/ EPA is registered should be obvious from the face of the document, but registration can be checked via the OPG’s registration database: <https://www.gov.uk/government/publications/search-public-guardian-registers>
* check the terms of the document to understand its extent: e.g. a LPA may grant decision making powers in respect of some areas of personal welfare and not others, or only some aspects of the donor’s property and finances; an ADRT may not be applicable to the particular care and treatment situation which has arisen.

Category two: arrangements made on behalf of the individual once capacity is lost

1. Court of Protection (CoP) orders: the CoP can make particular decisions on an individual’s behalf, or appoint a deputy to make property-related and financial decisions, and/ or health and welfare decisions on the individual’s behalf as and when they arise
2. MCA section 5: s5 states that those delivering care and treatment, whether paid or unpaid, are not liable for non-negligent care and treatment providing that they comply with the provisions of s5 (reference should also be made to s6). More limited provisions in respect of necessary expenditure made on behalf of an incapacitous individual can be found at sections 7 and 8.

If no valid or applicable arrangements were made by the adult when capacitous, and capacity has been lost in respect of the decision in question, it will be necessary to consider the options at category two a) and b) above. Where a deputy has been appointed to make the decision in question, that deputy is the decision maker. As noted above with regard to LPAs/ EPAs, care practitioners must seek and retain a copy of the CoP order appointing the deputy, and check the extent of the appointment/ decision making authority. It should be noted that deputies for health and welfare are appointed less often than for property and finances. Where deputies are appointed for health and welfare, their authority is more limited than that generally granted to health and welfare attorneys.

Practitioners may wish to utilise the template at Appendix F to record a best interests decision made by an attorney or deputy.

Where no deputy has been appointed to make the decision in question, care practitioners will need to consider whether it is appropriate to rely on the provisions of s5 (reference should also be made to s6) or whether a CoP application is needed. MCA s5 relates only to care and treatment matters; it does not authorise provision of care and treatment but exempts those providing it from liability, provided all provisions within s5 are met; the provisions within s6 will often be equally relevant. Utilising the tools in the appendixes to this policy will help care practitioners to comply with s5 and 6.

The Code gives guidance on when an issue-specific CoP application should be made (see in particular paragraphs 6.18-6.19 and 8.18-8.24). Since production of the Code, the CoP has clarified requirements regarding whether clinically assisted nutrition and hydration (CANH) can be withdrawn from someone with a prolonged disorder of consciousness (including a persistent vegetative state (PVS) or minimally conscious state (MCS); see An NHS Trust and Ors v Y [2018] UKSC 46. More general guidance can be found via the Medical Treatment Guidance issued by the CoP in January 2020 ([2020] EWCOP 2).

Guidance on decisions to withdraw CANH from patients in PVS or MCS has been published by the British Medical Association, Royal College of Physicians and General Medical Council; it can be found at <https://www.bma.org.uk/advice/employment/ethics/mental-capacity/clinically-assisted-nutrition-and-hydration>.

Where the most appropriate option is likely to be an application to appoint a property and finances and/ or a personal welfare deputy to make on-going decisions for an individual, care practitioners are expected to make the individual’s appropriate family members, friends etc aware of this option and direct them towards the guidance available at: <https://www.gov.uk/become-deputy>.

In the case of those under 18 (who are legally unable to execute LPAs or ADRTs) it will always be necessary to consider the options at category two a) and b), or to seek an alternative to the MCA such as parental authority, appropriate provisions of the Children Act 1989 or MHA. Application to the High Court (as opposed to the CoP) may be appropriate in some circumstances.

## 4.3 Principle Three: unwise decisions, incapacitous refusals of care and the role of others in individuals’ accessing care

All individuals with capacity may make decisions which others feel to be unwise, such as smoking and consuming alcohol, or refusing medical treatment. An individual *“who has the capacity to take a decision for himself may do so for a good reason, a bad reason or no reason at all. The 2005 Act reflects this by providing, in s1(4), that ‘a person is not to be treated as unable to make a decision merely because he makes an unwise decision’”* (N v A CCG and others [2017] UKSC 22, para 34).

Assessing whether an apparently unwise decision is or is not a capacitous choice can be difficult, particularly where an individual can clearly understand, retain and communicate information relevant to the decision. An inability to use/ weigh information may be evidenced where an individual is unable to give effect to responses they have given in the abstract, when faced with concrete situations i.e. their executive functioning is impaired. Detailed and clearly recorded capacity assessments are especially crucial for those with impaired executive functioning.

The MCA aims to balance an individual’s right to make decisions for themselves with their right to protection from harm if they lack capacity to make decisions to protect themselves. Where an individual repeatedly makes unwise decisions which leave them at significant risk, or their unwise decision appears irrational or out of character, further exploration may be warranted. Care practitioners should consider not just whether or not the individual has capacity, but other factors such as whether they are under pressure from someone else to make (or not make) a particular decision.

General case study guidance can be found at <https://www.scie.org.uk/mca/practice/decision-making/unwise-decisions>

### 4.3.1 incapacitous refusals of necessary care

Care should be taken not to mistakenly categorise incapacitous rejections of help as unwise decisions or ‘lifestyle choices’. Where an individual may lack capacity to make decisions regarding care and treatment, practitioners should not accept a refusal of necessary care without further consideration. Further consideration will be especially important where the implications for the individual could be significant.

Practice guidance on approaching individuals who refuse care or treatment can be found at Appendix H.

### 4.3.1.1 known refusers of necessary care

The case of R (on the application of McGuire) v HM Coroner Blackpool & Fylde [2020] EWCA Civ 738 has highlighted the importance of identifying incapacitous individuals who are likely to place themselves at risk by refusing necessary care/ treatment (for example, they have a history of refusing to cooperate with such).

The Partners intend that they and their Care Delivery Partners will have in place systems and processes which facilitate identification of key factors and appropriate proactive responses designed to:

* Save life and improve access to urgent care
* Reduce risks that could, or ought to have been, foreseen
* Enhance person centred care planning, in individual best interests
* Evidence that preventative frameworks operate to deliver the above, and thus
* Avoid challenges of systemic dysfunction and/ or failure to properly utilise legal safeguards.

Where individuals are likely to be at risk, practitioners should, with others, act proactively to ensure:

* The individual has a care plan which sets out in advance how necessary medical and/ or ancillary treatment will be accessed by them, where it is urgent, and they are refusing to cooperate. Be clear who will lead on creation of the plan
* All relevant parties have been included in the creation of such care plan to accurately reflect the individual’s best interests (such as their GP, other relevant professionals (for example, their advocate), and those interested in their welfare); the individual should be included, and be supported to be included, wherever possible and practicable, in the development of a plan
* A copy of the plan is shared with relevant professionals (such as the ambulance service), or mechanisms are in place to share, as required to facilitate the individual’s access to necessary medical and/ or ancillary treatment, as well as key others (such as Best Interests Assessors (BIAs))
* The plan is drafted in accordance with the MCA, including in particular by ensuring that any actions taken in the individual’s best interests are necessary, proportionate, and follow proper consideration of less restrictive options
* The plan is regularly reviewed and updated to ensure that the individual’s current circumstances are taken into account. Consideration of whether the plan continues to be appropriate will include reference to whether the plan and its content remain necessary, proportionate and focused on less restrictive options
* The plan is reflected in the care and treatment arrangements for which any authorisation for deprivation of liberty is in place. Where no such authorisation is in place, consideration will be given to whether the plan, in combination with other care and treatment arrangements, amounts to a deprivation of liberty requiring authorisation (in other words, whether the degree of any force or restraint of the individual may go beyond the protection provided by s5/6 of the MCA)
* Consideration is given to whether the treatment amounts to a) serious medical treatment and/ or b) serious interference with the individual’s rights under the ECHR, requiring the involvement of the court (guidance on CoP involvement in medical treatment was revised in January 2020 and care be read at <https://www.bailii.org/ew/cases/EWCOP/2020/2.html>).

Consideration of known refusers of care is also referenced in the practice guidance at Appendix H.

### 4.3.1.2 administration of necessary medication without consent

Case law (AG v BMBC and SNH [2016] EWCOP 37) indicates that prescription and administration of medication for those lacking capacity to consent to it is an area of practice requiring additional guidance. The issues pertinent to provision of medication without consent (and in particular, covert medication) are similar to those referred to above, in respect of advance care planning for known refusers of necessary care. In summary, where an individual is likely to refuse necessary medication, plans should be in place to ensure that resulting risks are mitigated.

A suite of guidance aimed at GPs, acute staff, non-medical and mental health prescribers, and residential and domiciliary care providers can be found at Appendix G. Appendix G also includes a condition for use by BIAs, where relevant, in the context of deprivation of liberty authorisations.

### 4.3.2 the role of others in individuals accessing care

In the same way that an incapacitous individuals’ refusal of necessary care should not be accepted without further consideration, refusal by their relatives (or others) should not be accepted without further consideration. Such consideration may be especially important where there is a pattern of refusal, e.g., a repeated failure to support the individual to attend appointments, or to allow access to the individual’s home by statutory services. It may be that the refuser has failed to appreciate the implications of their purported refusal on behalf of the individual, perhaps because of the refuser’s own lack of capacity or for other reasons.

Consideration of the role of others in individuals accessing care is also referenced in the practice guidance at Appendix H.

### 4.3.2.1 obstructing access to necessary care/ treatment

Where it appears that relatives (or others in the individual’s life) are refusing to allow the individual to access necessary care, care practitioners should ensure:

* They ascertain the reason for the refusal, and consider whether (for example) any fears that the refuser may have in connection with access to care can be mitigated. It may be that the refuser would welcome further support for themselves, for instance via the Carers’ Support Service
* They identify what authority the refuser has to make decisions on the individual’s behalf i.e., as an attorney or deputy. Copy documents should be sourced and lodged with the individual’s records; practitioners must be sure that the authority granted by the documents applies to the circumstances that have arisen
* That refused access – even where made with lawful authority – is challenged if the practitioner considers that the refuser is not acting in the individual’s best interests. A safeguarding referral should be made where relevant, and additional action may be required via the CoP.

A template has been created at appendix F to support practitioners in recording best interests decisions made by an attorney or deputy.

Further guidance on obstructing access to necessary care/ treatment is referenced in the practice guidance at Appendix H.

### 4.3.2.2 the inherent jurisdiction of the High Court

Where it appears that a vulnerable individual has capacity to make relevant decisions, but may be under some form of constraint, subject to coercion or undue influence or for some other reason deprived of the ability to make or express their free choice, the inherent jurisdiction of the High Court should be considered. The primary purpose of the inherent jurisdiction has been broadly described as to “allow the individual to be able to regain their autonomy of decision making” (London Borough of Croydon v KR & Anor [2019] EWHC 2498 (Fam), para 40). For further guidance on using the inherent jurisdiction, go to: <https://www.39essex.com/mental-capacity-guidance-note-inherent-jurisdiction/>.

## 4.4 Principle four: best interests decision making

Best interests’ is not defined by the MCA. Assessing best interests might best be considered as a process of constructing a decision on behalf of an individual who is unable to make that decision themselves. A conclusion as to what is in an individual’s best interests “is a decision about what would be best for this particular individual, taking into account, so far as practicable, his individual characteristics, likes and dislikes, values and approach to life” (N v A CCG[2017] UKSC 22 para 34).

MCA s4 sets out what must be considered when determining an individual’s best interests. Care practitioners must do whatever is reasonably practicable to encourage the individual’s participation as fully as possible in any decision affecting them. Particular importance should be placed on ascertaining the individual’s past and present wishes and feelings, and any other factors the individual would be likely to consider if they could; this will include consideration of any advance decisions which exist but which not valid or applicable (i.e. not legally binding), as they may still offer an authoritative indication of the individual’s wishes.

Whilst the purpose of the best interests test is to consider matters from the individual’s point of view, the MCA currently stops short of requiring best interests decisions to function as a straightforward ‘what P would have done’ test (Briggs v Briggs (no 2) [2016] EWCOP 53). Nevertheless, the weight to be given to the reliably ascertainable views of the individual are likely to be substantial. As the CoP noted in Avon and Wiltshire MH Partnership v WA [2020] EWCOP 37, “The weight to be attributed to P's wishes and feelings will of course differ depending on a variety of matters such as, for example, how clearly the wishes and feelings are expressed, how frequently they are (or were previously) expressed, how consistent P's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views)”. It seems likely that where it is possible to identify the course of action the individual would have taken if capacitous, departure from that course of action must be justified by the care practitioners involved. The greater the departure, the more compelling must be the reason and evidence for it (see further the 39 Essex Chambers’ Best Interests Assessments Guide, referenced below).

The views of others should be secured via consultation with anyone previously named by the individual as someone to be consulted, anyone caring for the individual, their close relatives or friends, and any attorney or deputy. Care practitioners are reminded of the need to include advocates where relevant (see also paragraph 4.2.1).

A discussion which (for example) takes place across a series of phone calls may suffice to make a best interests decision. A meeting at which all parties are physically present may not be necessary, although in cases of dispute or complexity, a meeting is likely to be the most productive method of establishing the best way forward. The nature and extent of the consultation must be proportionate to the circumstances.

The need to consult must be balanced with the person’s right to confidentiality.

It is important to be clear that not all decisions involving an individual lacking capacity are best interests’ decisions. In most cases involving delivery of healthcare or provision of social care there will be 2 stages:

1. A decision by the health or social care professionals as to what options to offer, taking into account the relevant duties on those professionals (e.g. in the case of social care, the duties imposed by the Care Act 2014 to assess and meet eligible needs). This is not a best interests decision because it is not a decision that the individual themselves could take
2. A best interests decision that is reached by a collaborative process, on the individual’s behalf, as to which of the options to accept. Note: only actually available options are relevant to decision making (A Local Authority v X [2016] EWCOP 44).

Practitioners must also recognise that best interests decisions may not relate solely to individuals’ health and care; consideration for physical, mental and emotional wellbeing may need to be balanced with financial wellbeing. When deciding which available care option is in an individual’s best interests, financial implications must be considered where relevant. For example, when selecting a social care package for self-funding individuals, practitioners should ensure that cost effectiveness is considered alongside need, taking into account the relative cost of each option, and the ongoing financial commitment involved.

When making a best interests’ decision, care practitioners are expected to select the most appropriate tools from those at Appendix E. Which tool is the most appropriate will depend on the circumstances in which best interests decisions are made; what is required to evidence a reasonable belief as to an individual’s best interests in the context of an A&E department at 3am will be very different from what may be required when deciding whether an elderly person with dementia should move from their home of 60 years into a care home. This example is given in 39 Essex Chambers’ Best Interests Assessments Guide; the guide can be found at <https://www.39essex.com/mental-capacity-guidance-note-best-interests/> Guidance is also available from SCiE at <https://www.scie.org.uk/mca/practice/best-interests/>.

## 4.5 Principle five: less restrictive practice

Care practitioners are required to evidence consideration of whether proposed care and/ or treatment:

1. is in the individual’s best interests (by reference to the MCA’s s4 ‘checklist’)
2. is necessary and proportionate in the circumstances, and
3. that no less restrictive option is available than the one proposed.

Any use of restrictions must be kept under review.

Proper consideration of less restrictive options, as part of a rights-based approach to care and planning, is intended to improve provision and, in particular, to avoid unnecessary and inappropriate deprivations of liberty. With regard to deprivations of liberty, care practitioners must be clear why no less restrictive options are available.

Care practitioners are reminded not only that restrictions can amount to a deprivation of liberty, but also that where more than minimal restraint is required to administer care and treatment, that may be because the individual objects to receiving it. In addition to considering the requirements of s6 (as to best interests, necessity and proportionality), practitioners may also need to consider whether an application to the CoP is required. For example, where a best interests decision indicates that an incapacitous individual should be cared for in a residential setting, but the individual objects to removal from their home and is likely to resist it, legal advice should be sought with a view to making a CoP application.

Guidance on using the MCA’s principles in care planning, including the importance of planning for a less restrictive option in any situation, is available from SCiE at <https://www.scie.org.uk/mca/practice/care-planning/key-principles-in-care-planning>.

### 4.5.1 Deprivation of Liberty

Via this policy, the Partners seek to ensure that all those for whom they are responsible are enabled to access their entitlements under the ECHR. This is particularly relevant for those deprived of their liberty.

Where individuals are deprived of liberty in their best interests, such deprivations will be authorised via the most effective and lawful mechanisms available. The DoLS team at Focus supports the process of securing appropriate authorisation for deprivations, whether those deprivations arise in standard or non-standard settings.

In standard settings, some individuals may be eligible for detention under the MCA or MHA. A Memorandum of Understanding (MoU) has been developed to support authorisation of deprivations in a hospital setting, where careful consideration of the most appropriate authorising statute is required. Practitioners are asked to note in particular that disputes regarding choice of regime should be resolved peer to peer in the first instance, with support from their respective line managers where necessary. Where resolution fails at this level, disputes will be managed by the leads identified within each Partners’ organisation (see page 6 of the MoU). The MoU can be accessed at: <https://www.northeastlincolnshireccg.nhs.uk/publications/> (under the heading Adult Services Publications and Policies).

Drawing on guidance issued by the Association of Directors of Adult Social Services (ADASS) in April 2016 (‘Advice Note for Managing and Processing Cases Generated by the Supreme Court Decision in 2014 in relation to Deprivation of Liberty Safeguards’), a lighter touch approach to authorisation of existing deprivations of liberty in standard settings (referred to as ‘renewals’) has been adopted. Use of this lighter touch approach for deprived individuals in standard settings, who are on the Partner’s waiting list and deemed to be a lower priority, has been successfully trialled; it is hoped that the approach will also be adopted for appropriate cases in this cohort where practitioner capacity allows.

Potential deprivations are considered using the ADASS ‘screening tool to prioritise the allocation of requests to authorise a deprivation of liberty’ (see ADASS advice note ‘Guidance for Local Authorities in the light of the Supreme Court decisions on deprivation of liberty safeguards’ November 2014). Those deprived of liberty in both standard and non-standard settings who are on the waiting list for assessment are regularly reviewed by reference to similar criteria to ensure that changes in individual circumstances are proactively identified and responded to.

Conditions attaching to authorisations in standard settings are regularly monitored by the DoLS Team, and considered by BIAs on renewal. Managing authorities are expected to provide proportionate evidence of how they are complying with conditions. Non-compliance is recorded on the ICB’s intelligence portal, a referral made to safeguarding (01472 256256) if relevant, and followed up by the ICB contracting team (follow up depends on the nature and severity of the breach).

In standard settings, managing authorities are required to seek authorisation for deprivations of liberty on their premises; however, deprivations in non-standard settings do not benefit from an equivalent managing authority role. In non-standard settings, where care practitioners identify that the individual’s care and treatment could constitute a deprivation of liberty, they are expected to raise such potential deprivations with the individual’s key worker, or in the absence of such key worker, with the Single Point of Access (01472 256256).

A range of documents have been developed setting out the Partner’s approach to deprivations in non-standard settings; these can be found at <https://livewell.nelincs.gov.uk/>. The documents include the criteria applicable to provision of a proposed Rule 1.2 Representative where one is required as part of CoP processes.

## 5 Training

This policy will be drawn to the attention of all relevant individuals as part of the implementation process (see 7 below).

As already noted, all relevant staff must undertake MCA training commensurate with their role in line with the National Mental Capacity Forum’s MCA Competency Framework, and continue to maintain their knowledge of, and ability to apply, the MCA. The Partners wish to make special mention of the expectations of those supervising and/ or managing staff at the ‘front line’, in respect of MCA training. Whilst organisational training plans are often focused on equipping practitioners with regular patient/ service user contact with the skills they need to apply the MCA (and this policy), the knowledge of their supervisors/ managers is equally important. Leaders cannot lead without the knowledge to do so.

The Partners have committed themselves to developing a legally literate workforce able to champion rights-based care. Achieving this objective is reliant in significant part on supervisors/ managers drawing on their own sound understanding of the law and this policy, to support their staff to do likewise. For this reason, it is expected that those in leadership roles will undertake and maintain their MCA training at the same level as frontline staff.

## 6 Impact analysis

### 6.1 Equality

This policy has been created with due regard for the ICB’s public sector equality duty under the Equality Act 2010, s149. All staff connected with the implementation of this policy, in the exercise of their public functions, must also have due regard to the matters within s149(1).

An Equality Impact Assessment (EIA) has been conducted with regard to this policy. Two areas of concern have been identified: whilst the policy itself is unlikely to have an impact on grounds of race, it is recognised that some nationalities may have difficulties understanding the policy due to limited English Language skills. Similarly, whilst the policy itself is unlikely to have an impact on grounds of disability, it is recognised that those with sensory impairments or with specific communication needs may have difficulties accessing the policy. Mitigating actions are set out within the EIA which can be accessed [here](https://portal.yhcs.org.uk/documents/5665646/17351999/EIA+Mental+Capacity+Act+2005+and+Deprivation+of+Liberty+Policy/23bfbcd8-cf72-484b-9488-18b51a5a6bee).

### 6.2 Bribery Act 2010

The Bribery Act 2010 is relevant to this policy. Under that Act it is a criminal offence:

* To bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
* To be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so
* To bribe a foreign public official - A person will be guilty of this offence if they promise, offer or give a financial or other advantage to a foreign public official, either directly or through a third party, where such an advantage is not legitimately due
* For commercial organisations to fail to embed preventative bribery measures.  This applies to all commercial organisations which have business in the UK. Unlike corporate manslaughter this does not only apply to the organisation itself; individuals and employees may also be guilty.

These offences can be committed directly or by and through a third person and other related policies and documentation when considering whether to offer or accept gifts and hospitality and/or other incentives.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist.

## 7 Implementation

The Partners seek to ensure that the care and treatment they deliver, and all those from whom they commission such care and treatment, have processes and systems in place to support lawful implementation of the MCA. Each Partner and Care Delivery Partner is responsible for ensuring compliance with the MCA within and across their organisation; each will ensure that they create detailed procedures setting out how this policy, the MCA and its Codes of Practice, apply to their respective operational settings. This includes taking account of and responding to changes to the law, and to developing case law in particular. The Partners consider that this process of review and revision should take place no less than annually, to ensure that rapidly changing areas of the law receive a timely response.

This policy will be disseminated by the Partners and each Care Delivery Partner with the expectation that each will cascade the information within it amongst their relevant staff/ teams. The policy will be lodged on the CCG’s website and accessible via LiveWell <https://livewell.nelincs.gov.uk/>); the Partners and Care Delivery Partners are expected to ensure that it is available electronically to their staff. The policy will be further communicated through team briefings, and training sessions.

Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under each Partner’s respective disciplinary procedure, or that of the Care Delivery Partner responsible for the staff member in breach.

The policy is publicly available at: <http://www.northeastlincolnshireccg.nhs.uk/publications/>

## 8 Monitoring and review

This policy will be reviewed in 12 months. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in law/ guidance, as instructed by the senior manager responsible for this policy.

## 9 References and links to other documents

### 9.1 references

1. European Convention on Human Rights
2. UN Convention on the Rights of People with Disabilities
3. The NHS Constitution
4. The Mental Health Act 1983
5. The Human Rights Act 1998
6. The Mental Capacity Act 2005
7. Mental Capacity Act Code of Practice 2007: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf>
8. Deprivation of Liberty Safeguards Code of Practice 2008: <http://webarchive.nationalarchives.gov.uk/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476>
9. Equality Act 2010
10. Care Act 2014
11. Assessment of Mental Capacity: a Practical Guide for doctors and Lawyers, BMA and the Law Society (editor Alex Ruck Keene), fourth edition 2015
12. Deprivation of Liberty: Collected Guidance, Law Society 2016 <http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>
13. Lasting Powers of Attorney: a Practical Guide, third edition, Law Society 2016
14. Court of Protection Handbook: a user’s guide, Ruck Keene, Edwards, Eldergill, Miles; second edition, Legal Action Group 2017
15. North East Lincolnshire Adult Strategy 2019 (accessible via: <https://www.northeastlincolnshireccg.nhs.uk/publications/>)

### 9.2 useful links

* Lasting Powers of Attorney can be executed at <https://www.gov.uk/government/publications/make-a-lasting-power-of-attorney>
* Applications to the Court of Protection can be made at <https://www.gov.uk/courts-tribunals/court-of-protection>
* A basic guide to the Court of Protection can be found at <https://courtofprotectionhandbook.com/case-law-practical-guidance-and-useful-websites-2/>
* Office of the Public Guardian <https://www.gov.uk/government/organisations/office-of-the-public-guardian>
* Advance decisions or statements can be made at <https://mydecisions.org.uk/dashboard>
* Mental Capacity Act Guidance for professionals – Mental Capacity Toolkit (British Medical Association <https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit>
* Ministry of Justice <http://www.justice.gov.uk/about/mental-capacity.htm>
* A range of MCA-related resources and commentary can be found at <https://www.mentalcapacitylawandpolicy.org.uk/resources-2/>
* The ‘Deciding Right’ app enables professionals and organisations to be compliant with key legal and clinical frameworks, including the MCA. The app can be accessed at <http://www.necn.nhs.uk/common-themes/deciding-right/> and a supporting range of resources is available at <http://www.necn.nhs.uk/common-themes/deciding-right/resources/>

## APPENDIX A: Yorkshire and the Humber Mental Capacity Act Network

### GUIDANCE: REPORTING DEPRIVATION OF LIBERTY RELATED SAFEGUARDING CONCERNS

Failure to use the Mental Capacity Act (2005) correctly can result in abuse and breaches of a person’s human rights, including unlawful Deprivation of Liberty (DoL). Similarly the process for authorising a deprivation of liberty can raise safeguarding concerns which must be acted upon. This guidance aims to promote a consistent approach to DoL-related safeguarding concerns across the region.

This document was originally approved for circulation in March 2011, however, the issuing of the Supreme Court Judgement in March 2014 and the operational impact ensuing has warranted a review of this document. A further update to this document was made in May 2017.

Safeguarding responses need to be proportionate and appropriate, with each situation being considered on its own merits according to local multi-agency safeguarding procedures (<https://www.focusadultsocialwork.co.uk/social-work/>). As part of this review much discussion was had around unacceptable practice and risk of harm and where a person may or has been subjected to actual harm. This has led to the creation of a **non-exhaustive** list of circumstances that may warrant the raising of a safeguarding concern or alternatively raise a contracting concern. It will not be appropriate in all circumstances to raise a safeguarding concern, and following list should assist in deciding how to report issues which may arise:

|  |
| --- |
| **Consider raising a safeguarding concern:** |
| **A DoL cannot be authorised**: (Excluding situations where the eligibility assessment indicates that a Mental Health Act assessment should take place) for example:   * *The deprivation is not in the person’s best interest, including restrictions being significantly disproportionate / not the least restrictive.* * *DoL conflicts with a valid Advanced Decision or decision by Court Appointed Deputy / proxy and it has not been acted upon.* |
| **Risk or harm resulting from failure to follow procedures:** Risk or harm resulting from any party failing to follow procedures / guidelines / regulations / statute.  *Examples may include:*   * *Failure to review care regime when circumstances change and DoL is no longer required / person is no longer eligible/disproportionate restrictions.* * *Actual harm resulting from inadequate care planning and record keeping.* * *Failure to do anything if person suffers harm.* |
| **Other safeguarding concern(s) identified during DoL(S) process:** Any other safeguarding concern raised during the DoL(S) process that meets the criteria for using local multiagency safeguarding procedures. The provisions in s.6 of Mental Capacity Act should be referred to in such circumstances.  *Examples may include:*   * *A concern / charge of wilful neglect or ill-treatment (Section 44 offence).* * *Safeguarding concerns unrelated to the actual DoL or relevant person, such as financial or psychological abuse.* * *Any abusive institutional practices.* |

|  |
| --- |
| **Consider raising a contracting concern:** |
| **An unauthorised DoL**: Where a deprivation of liberty is occurring and the managing authority, or appropriate Local Authority or ICB, have not made an application for authorisation.  *Examples may include:*   * *Longstanding (pre-existing) DoL without timely DoL application* * *Hospital or care home, Local Authority or ICB, fail to act appropriately or in a timely manner, when made aware of a potential DoL (e.g. by person, visitor, relative or staff).* * *An unauthorised DoL is confirmed after being reported to the appropriate Local Authority or ICB, by a 3rd party.* * *Continuing DoL after an authorisation has ended and no further application has been made.* * *Restrictions not authorised by consent,* * *Non-compliance with conditions* |
| **Risk or harm resulting from failure to follow procedures:** Risk or harm resulting from any party failing to follow procedures / guidelines / regulations / statute.  *Examples may include:*   * *Failure to notify CQC/NPSA in line with statute & regulations.* * *Failure to request an IMCA where required.* * *Risk of harm resulting from inadequate care planning and record keeping.* * *Failure to notify the appropriate Local Authority or ICB of issues that may need referring to the CoP e.g. objections* |

**It should be noted that the above examples are non-exhaustive and the course of action will depend upon the individual circumstances of each case.**

**Safeguarding concerns should be reported via 01472 256256.**

## APPENDIX B: Triggers and Responses

**Triggers and responses**

**Scope and Definitions**

Within this document:

* The person requiring care and treatment and/ or intervention is referred to as ‘P’
* P is envisaged to be over 18; additional/ different considerations apply where P is not over 18
* P lacks capacity in relation to a matter if they are not able to make a decision at the time it needs to be made. Lack of capacity is defined by whether P is unable to understand, retain or use/ weigh the information needed to make a decision, or to communicate it, because of an impairment or disturbance in the functioning of the mind or brain. Whether or not P lacks capacity in relation to a particular decision at the time it needs to be made is established ‘on the balance of probabilities’
* For P’s consent to be valid it must be a) voluntary, b) informed, and c) capacitous
* A best interests’ decision results from taking account of all factors listed in s4 of the Mental Capacity Act 2005, including consideration of P’s wishes and feelings (such as an Advance Statement of Wishes), P’s beliefs and values and anything else P may be likely to consider if they were able. It includes consultation with P’s ‘relevant others’ (see below)
* A valid and applicable Advance Decision to Refuse Treatment (ADRT) is a decision with legal status, relating to medical treatments which P wishes to refuse. It is valid if there is no evidence that P has altered their decision since the ADRT was made, and it is applicable to the treatment proposed. P’s advance decision may be communicated verbally or in writing; it must be in writing where it relates to life-sustaining/ life-saving treatment
* P’s ‘relevant others’ includes anyone named by P as a person to involve/ consult, anyone engaged in caring for P, anyone interested in P’s welfare such as family members, and anyone appointed by P. An attorney or deputy may have been appointed by P to take the decision in question on their behalf; an attorney/ deputy without authority to take the decision in question should nevertheless be involved. Relevant others also includes advocates and RPRs (relevant person’s representatives). Who P’s relevant others are in a given case will depend on the extent of P’s capacity to choose, on choices made whilst P had capacity, and on practitioner’s judgement where P’s choices are unknown
* P’s care/ treatment amounts to a deprivation of liberty when they lack relevant capacity and are under continuous or complete supervision and control and are not free to leave (known as the “acid test”).

|  |
| --- |
| **1. Referral**  Considerations on receipt of a referral:   1. Referral made by P: where there is no reason to depart from the statutory presumption of capacity, accept referral 2. Referral made by someone other than P: explicit consent is required from P, unless P lacks capacity to consent, in which case referral should only be accepted where - 3. P’s attorney or deputy (with relevant authority) makes, or gives consent to, the referral; request full copy attorney/ deputyship documents (unless already recorded on the system) 4. there is no attorney or deputy with relevant authority – or it is unknown/ unconfirmed whether P has such an attorney/ deputy - and referral is in P’s best interests (record that referral is proceeding on this basis)   NB P’s known refusal to consent is no reason to automatically reject the referral if P lacks capacity to understand the nature and effect of such refusal; in these circumstances, consent should be secured from P’s attorney/ deputy (as at b)i)), or accepted where referral is in P’s best interests (as at b)ii))   1. Referral without consent can be accepted in circumstances where 2. the lack of P’s consent is overridden by the Mental Health Act 1983 3. the referral relates to concerns about P’s welfare where P is suffering or likely to be suffering abuse or neglect BUT NOTE  * wherever practicable P’s consent should have been sought before referral (it is good practice for the referrer to inform P that the referral is being made, unless doing so would increase the risk of harm) * whether or not P has capacity to consent, referral should be accepted if others are or will be put at risk if the referral is not accepted, or where it is in the public interest to accept the referral because a criminal offence has occurred   IN THIS DOCUMENT, SAFEGUARDING CONSIDERATIONS ARE NOT INCLUDED BEYOND THE POINT OF REFERAL. THE REMAINDER OF THIS DOCUMENT FOCUSES ON CARE AND TREATMENT INTERVENTIONS, EXCLUDING SAFEGUARDING CONSIDERATIONS. FIND OUT MORE ABOUT SAFEGUARDING AT: <https://www.focusadultsocialwork.co.uk/social-work/>  **Nothing in this section is intended to indicate that referrals should be refused where consent cannot be obtained and it is immediately necessary to proceed to save life or avoid significant deterioration in P’s circumstances.** |

|  |
| --- |
| **Consider advocacy**  If it is evident that P is likely to need an advocate (under the Care Act 2014, Mental Capacity Act 2005 or Mental Health Act 1983), ensure that this information is passed on to whomever is receiving the referral and/ or create the advocacy referral to avoid delay. |

|  |
| --- |
| **2. Assessment/ Investigation**  Considerations regarding assessment/ investigation:   1. P consents to assessment/ investigation and there is no reason to depart from the statutory presumption of capacity – proceed 2. P lacks capacity to consent to assessment/ investigation\* – proceed IF 3. assessment/ investigation does not conflict with any known valid and applicable ADRT (where the ADRT is written, ensure it is stored on the system and its consideration is evidenced) 4. P’s attorney or deputy (with relevant authority) gives their consent to the assessment/ investigation (where an attorney/ deputy is appointed, assessment/ investigation should not proceed without their consent, other than where there is an urgent need to proceed in P’s best interests; ensure copy attorney/ deputyship documents are stored on the system) 5. there is no attorney or deputy with relevant authority - or it is unknown/ unconfirmed whether P has such an attorney/ deputy - and assessment/ investigation is in P’s best interests, is necessary and proportionate in the circumstances and represents the less restrictive option (record that assessment/ investigation is proceeding on this basis; the extent of the recording depends on the extent of the intervention)   NB In the absence of any known valid and applicable ADRT (as at bi)), P’s refusal to consent is no automatic reason not to proceed *if* P lacks capacity to understand the nature and effect of such refusal; in these circumstances, consent should be secured from P’s attorney/ deputy (as at b)ii)), or assessment/ investigation can continue where this is in P’s best interests (as at b)iii))   1. Assessment/ investigation can proceed in circumstances where the lack of P’s consent is overridden by the Mental Health Act 1983  * IN ALL CASES, ENSURE THAT P’S RELEVANT OTHERS ARE INVOLVED AS APPROPRIATE, AND THAT P IS SUPPORTED BY AN ADVOCATE WHERE REQUIRED -   \* It is assumed that reasonable steps have been taken to establish P’s lack of capacity to consent to assessment/ investigation, and that such steps have been evidenced. It is only appropriate to rely on implied consent in the case of routine/ minor investigations if the care professional is satisfied that P understands what is proposed and why. If in doubt regarding P’s capacity, implied consent is unlikely to be appropriate, and it may be necessary to formally assess capacity to consent.  **Nothing in this section is intended to indicate that assessment/ investigation should be refused where consent cannot be obtained and it is immediately necessary to proceed to save life or avoid significant deterioration in P’s circumstances.** |

|  |
| --- |
| **3. Planning for Care and Treatment and/ or Delivery**  Considerations regarding care and treatment planning/ delivery:   1. P consents to care and treatment planning/ delivery and there is no reason to depart from the statutory presumption of capacity – proceed 2. P lacks capacity to consent to care and treatment planning/ delivery\* – proceed IF 3. the care/ treatment does not conflict with any known valid and applicable ADRT (where the ADRT is written, ensure it is stored on the system and its consideration is evidenced before proceeding). NB some decisions regarding medical treatment should be brought before the Court of Protection; more information can be found in the Medical Treatment Guidance issued by the CoP in January 2020 ([2020] EWCOP 2) 4. P’s attorney or deputy (with relevant authority) gives their consent to the care/ treatment planning/ delivery (where an attorney/ deputy is appointed, care/ treatment planning/ delivery should not proceed without their consent, other than where there is an urgent need to proceed in P’s best interests; ensure copy attorney/ deputyship documents are stored on the system) 5. there is no attorney or deputy with relevant authority - or it is unknown/ unconfirmed whether P has such an attorney/ deputy - and care/ treatment planning/ delivery is in P’s best interests, is necessary and proportionate in the circumstances and represents the less restrictive option (record that care/ treatment planning/ delivery is proceeding on this basis; the extent of the recording depends on the extent of the intervention)   NB In the absence of any known valid and applicable ADRT (as at b)i)), P’s refusal to consent is no automatic reason not to proceed *if* P lacks capacity to understand the nature and effect of such refusal; in these circumstances, consent should be secured from P’s attorney/ deputy (as at b)ii)), or care/ treatment planning/ delivery can continue where this is in P’s best interests (as at b)iii))   1. Care and treatment planning/ delivery can proceed in circumstances where the lack of P’s consent is overridden by the Mental Health Act 1983 2. Where P’s care/ treatment is likely to amount to a deprivation of their liberty, planning includes seeking authorisation of the deprivation (urgent authorisations may be necessary in some cases) 3. Ensure proportionate provisions for review are built into P’s care/ treatment planning / delivery      * IN ALL CASES, ENSURE THAT P’S RELEVANT OTHERS ARE INVOLVED AS APPROPRIATE, AND THAT P IS SUPPORTED BY AN ADVOCATE WHERE REQUIRED -   \* It is assumed that reasonable steps have been taken to establish P’s lack of capacity to consent to care/ treatment planning/ delivery, and that such steps have been evidenced. Whether the steps taken to establish capacity are reasonable will depend on the context and implications of the care/ treatment planned/ delivered. P’s capacity to consent to any charges which P may incur as a result of care/ treatment will also need to be considered and evidenced, where relevant.  **Nothing in this section is intended to indicate that care and treatment planning and/ or delivery should be refused where consent cannot be obtained and it is immediately necessary to proceed to save life or avoid significant deterioration in P’s circumstances.** |

|  |
| --- |
| **4. Planning for Discharge/ making Post-discharge Arrangements**  Considerations regarding discharge:   1. P consents to discharge planning/ post-discharge arrangements and there is no reason to depart from the statutory presumption of capacity – proceed 2. Where P lacks capacity to consent to discharge planning/ post-discharge arrangements\* the following considerations apply: 3. ensure post-discharge arrangements do not conflict with any known valid and applicable ADRT (where the ADRT is written, ensure it is stored on the system and its consideration is evidenced before proceeding) 4. P’s attorney or deputy (with relevant authority) gives their consent to P’s discharge planning and making post-discharge arrangements (ensure copy attorney/ deputyship documents are stored on the system) 5. where there is no attorney or deputy with relevant authority - or it is unknown/ unconfirmed whether P has such an attorney/ deputy – planning/ arrangements facilitate post-discharge support which is in P’s best interests, is necessary and proportionate in the circumstances and represents the less restrictive option (record that discharge planning/ arrangements proceed on this basis; the extent of the recording depends on P’s circumstances including post-discharge) 6. if P’s post-discharge care/ treatment arrangements are likely to amount to a deprivation of their liberty, seek authorisation of the deprivation before proceeding (urgent authorisations may be necessary in some circumstances) 7. ensure proportionate provisions for review are built into P’s discharge planning   NB In the absence of any known valid and applicable ADRT (as at b)i)), P’s refusal to consent to planning/ post-discharge arrangements is no automatic reason not to proceed *if* P lacks capacity to understand the nature and effect of such refusal; in these circumstances, consent should be secured from P’s attorney/ deputy (as at b)ii)), or discharge planning/ post-discharge arrangements can continue where this is in P’s best interests (as at b)iii))   1. Lack of P’s consent to discharge planning may be overridden by the Mental Health Act 1983  * IN ALL CASES, ENSURE THAT P’S RELEVANT OTHERS ARE INVOLVED AS APPROPRIATE, AND THAT P IS SUPPORTED BY AN ADVOCATE WHERE REQUIRED -   \* It is assumed that reasonable steps have been taken to establish P’s lack of capacity to consent to discharge planning/ post-discharge arrangements, and that such steps have been evidenced. Whether the steps taken to establish capacity are reasonable will depend on the context and implications of the discharge planning/ post-discharge arrangements.  **Nothing in this section is intended to indicate that planning for discharge/ making post-discharge arrangements should be refused where consent cannot be obtained and it is immediately necessary to proceed to save life or avoid significant deterioration in P’s circumstances** |

## APPENDIX C – Proactively Recording Capacity (practice note)

**Capacity to consent to, and engage in, an assessment/ investigation**

Reliance on statutory presumption of capacity –

During my time with [ *client name* ] on [ *date* ] at [ *time* ] for the purpose of [ *e.g. attending on Mrs X to conduct an assessment/ investigation/ intervention etc*  ]

1. Nothing happened to cause me to question his/ her capacity for this decision/ purpose, and
2. There was no other evidence or information known or reasonably available to me

which (in my professional opinion), justifies departure from the presumption of capacity within s1(2) of the Mental Capacity Act 2005.

*NB the same approach would apply to care and treatment planning/ delivery, review/ follow up assessment and safeguarding enquiries.*

Departure from statutory presumption of capacity –

In my professional opinion [ *client name* ] on [ *date* ] at [ *time* ], on the balance of probabilities, lacks capacity for the purpose of [ *e.g. participating in an assessment of their care and support needs/ consenting to an investigation to identify their treatment needs*  ]. Having taken reasonable steps to establish that [ *client name* ] lacks capacity in relation to this matter, I have decided to [ *e.g. conduct the assessment* / carry out the investigation] in [ *client name* ]’s best interests. My decision was taken in conjunction/ consultation with [ *e.g. the client’s family member* ] on [ *date* ].

**Please note that the above, headed ‘departure from statutory presumption of capacity’ does not in and of itself, constitute a capacity assessment or a detailed best interest decision. Rather, it sets out the conclusion of the capacity assessment/ best interest decision. It is not therefore a substitute for a reasoned and recorded assessment of capacity/ best interests decision; rather, it offers wording which might be used to evidence within relevant documentation what the practitioner intends to proceed with on what basis. Such statements may be supported by further proportionate information in the form set out at Appendix D or otherwise. The example given here is capacity to consent to an assessment or initial investigations, which may be relatively modest in nature. In particular, capacity in relation to more complex matters, or matters where the implications for the individual are more significant, are likely to command a higher level of detail in recording.**

## APPENDIX D – Capacity Assessment Tools

The following capacity assessment tools are available via this policy:

* MCA assessment tool – short version

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-assessment-tool-short-version-april-2023-accessible-final.docx>

* MCA assessment tool – longer version (preparing and making a mental capacity assessment)

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-assessment-tool-longer-version-april-2023-accessible.docx>

* MCA combined assessment and best interests tool

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-assessment-and-bi-tool-combined-april-2023-accessible.docx>

## APPENDIX E – Best Interests Decision Guidance and Tools

**Aim**

The aim of this guidance is to support staff in becoming confident and competent in a) applying principles set out in the Mental Capacity Act 2005 (MCA) when making best interests decisions, and b) in recording the decision making process. Tools are provided to support recording. This guidance has been created primarily with health and welfare decisions in mind. It should be read in tandem with the MCA’s Code of Practice (<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>).

**An Overview of the MCA**

The MCA provides a framework to empower and protect individuals who lack the capacity to make decisions for themselves. The core principles of the MCA are:

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Principle two requires that all practicable steps must be taken to support an individual to make their own decision before any question of someone making the decision for them (via a best interests process) arises. The better the application of the MCA, the fewer best interests decisions will be required; the most desirable result of MCA processes is that the individual is supported to make their own decision (although this is not always practicable).

If it is established, on the balance of probabilities, that the individual does not have capacity to make the decision in question, then someone will need to make the decision for them (unless the decision can be postponed). Those proposing to make a decision on behalf of an incapacitous individual will need to confirm:

1. Whether, whilst capacitous, the individual made any valid and applicable advance decisions relevant to the decision in question
2. Whether, whilst capacitous, the individual granted anyone authority to make this decision for them i.e. an attorney
3. Whether anyone has been appointed by the Court of Protection to make the decision for them i.e. a deputy.

The documents setting out the individual’s advance decision and the terms of any appointment made by them or by the court, will need to be checked carefully to ensure they are applicable to the current circumstances and the decision in question. Where the documents are valid and applicable, follow them (and ensure a copy is retained on file).

The remainder of this document assumes that the reader has either confirmed that they are the decision maker with regard to the decision in question or that they are contributing to the decision making process of an appointed decision maker (i.e. an attorney or deputy).

**Overview of the best interests principle**

Where all efforts to help an individual make their own decision have failed, s4 of the MCA sets out the matters which must be considered when making a best interests decision on their behalf. The MCA does not define the term ‘best interests’ but lists considerations to help identify best interests (often referred to as the ‘s4 checklist’). In effect s4 provides a framework within which the decision making process takes place on an individual’s behalf; it does not provide a definitive answer regarding what is in an individual’s best interests. It is the decision-maker’s responsibility to work out what is in the best interests of the individual. It is possible for two care practitioners to reasonably apply the factors within s4 and arrive at different conclusions as to what is in an individual’s best interests.

The purpose of the best interests process is to consider matters from the individual’s point of view, and to arrive at a decision which the decision maker reasonably believes is the right one for the individual – rather than the outcome desired by professionals or others. Those consulted in the making of a best interests decision should not be presented with a fait accompli, but should be given a genuine opportunity to explore options and share views. All best interests decisions must be approached with an open mind, and not made on the basis of unjustified assumptions about the individual’s age, appearance, condition or behaviour.

The MCA requires decision makers to follow certain steps to help them work out whether a particular act or decision is in an individual’s best interests. Decision makers MUST consider all of the relevant circumstances (being those of which the decision maker is aware, and which it would be reasonable to regard as relevant), in addition to the ‘s4 checklist’:

1. Whether the individual will regain capacity to make the decision in question, and if so, when that is likely to be (i.e. can the decision be delayed)
2. So far as is reasonably practicable, permit and encourage the individual to participate as fully as possible in the decision making process
3. So far as reasonably ascertainable, consider the individual’s past and present wishes and feelings (including relevant written statements made when the individual had capacity), the beliefs and values likely to influence their decision if they had capacity and any other factors the individual would be likely to consider if able to do so
4. If practicable and appropriate, take into account the views of relevant others (i.e. anyone named by the individual as someone to be consulted on matters of this kind, anyone caring for the individual or interested in their welfare, and any attorney or deputy) as to what would be in the individual’s best interests
5. If the decision concerns life sustaining treatment, not be motivated by a desire to bring about the individual’s death.

There is no automatic priority, and the weight to be attached to each of the above considerations will depend on the individual’s circumstances. All considerations must be attended to, even if they are discarded as not relevant in the circumstances. Any option which is less restrictive of the individual’s rights and freedoms should also be considered, provided those less restrictive options are in the individual’s best interests.

Evidencing application of the ‘s4 checklist’ will be crucial to defending a decision in the event of any subsequent challenge. If the decision is urgent, there may not be time to examine all possible factors, but a record must still be kept of the process of working out the individual’s best interests. Care/ treatment should not be delayed when it is immediately necessary to save life or avoid significant deterioration in the individual’s circumstances.

Protection from liability

Sections 5 and 6 of the MCA offer protection from liability only when 5 conditions are satisfied:

1. The decision/ act proposed is in connection with the individual’s care and treatment
2. Before deciding/ acting, the decision maker takes reasonable steps to establish whether the individual can make their own decision in relation to the matter
3. When making the decision/ doing the act, the decision maker reasonably believes the individual lacks capacity to make their own decision in relation to the matter
4. The decision maker reasonably believes that they are acting in the individual’s best interests (see overview of best interests set out above)
5. If restraint is used to provide the care and treatment, the decision maker reasonably believes that restraint is necessary in order to prevent harm to the individual, and that such restraint is a proportionate response to the likelihood and the seriousness of the individual suffering harm.

Please note that nothing in s5 affects the operation of s24-26 i.e. advance decisions to refuse treatment, nor does s5 authorise decisions/ acts which conflict with the decision of

an attorney or deputy which is within the scope of their authority, and properly made in accordance with the MCA. It should also be noted that s5 does not offer protection from liability for criminal acts, or negligent treatment/ care.

Applying to the Court of Protection

Some decisions are so serious that the court has to make them – unless the individual has previously appointed an attorney to make the decision for them or they have made a valid and applicable advance decision to refuse a proposed treatment. An application should be made where, for example, the care and treatment is particularly intrusive, or there is a significant dispute about the individual’s best interests. Some decisions regarding life sustaining or serious medical treatment should be brought before the court. Seek legal advice where necessary.

**Key dos & don’ts:**

**Do**

Ensure that you are clear about what decision needs to be taken

Ensure that capacity has been properly assessed, and the individual is unable to make the decision in question themselves

Ensure that consideration has been given to whether the individual will regain capacity, and if so, whether the decision can wait

Ensure that you have identified the decision maker(s) for the decision in question (refer to the MCA’s Code of Practice at page 69)

Ensure that the individual is given an opportunity to participate in the decision making process, as far as practically possible

Let the people who know the individual tell you about them; give them time to tell you about the individual and their values, as well as their own views on the individual’s needs

Remain open minded about the outcome of a decision

Remember to follow the less restrictive principle

Ensure decisions are well documented, so they can be referred to at a later date.

**Don’t**

Don’t present a meeting as a place to ratify a decision that’s already been made

Don’t hold a formal best interest meeting without first investing time in supporting the relatives and carers to be there and able to contribute

Don’t tell people they are the decision maker for a decision they haven’t got the authority to take – or conversely, try to take a decision that you don’t have the authority to make

Don’t call a meeting if one isn’t needed – in appropriate circumstances, a best interests decision could take the form of a number of phone calls to a number of contributors

Don’t use a best interest meeting to resolve a family dispute (though family disputes may be raised there!) or to resolve inter-agency or inter-professional disagreements.

**Three options for recording a best interests decision process**

Choose one of the following three options according to the specific needs of the case/ decision in question:

**Option 1** – Best interests discussions can be considered for simpler decisions, at any time, not just at a meeting or forum. Best interests discussions usually take place where there is likely to be agreement amongst all stakeholders, or where there are only a small number of stakeholders. The template available via this document may be used in circumstances where the best interests decision takes place immediately after a capacity assessment; page one of the document features a simple capacity assessment, followed by the best interests decision tool on page two.

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-assessment-and-bi-tool-combined-april-2023-accessible.docx>

**Option 2 –** Best interests meetings (fairly informal) where the issues may be more complex or the risks higher. The template available via this document provides for consideration and recording of preliminary matters, before embarking on the best interests decision itself.

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-best-interests-tool-longer-version-april-2021.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-best-interests-tool-longer-version-april-2021.docx)

**Option 3 –** formal best interests meeting (the issues are complex and/ or contentious).The template available via this document is provided for use by a meeting chair and minute taker. Guidance for the chair and minute taker can be found at the rear of the document. A formal best interests meeting is generally expected to be accompanied by a pre and post meeting involving the individual’s family members/ relevant others. Careful planning of formal meetings, and defining ground rules, will be crucial to their success.

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-best-interests-meeting-template-april-2021.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/mca-best-interests-meeting-template-april-2021.docx)

## APPENDIX F – Recording a Best Interest Decision made by a Relevant Attorney or Court of Protection Deputy

A tool for recording best interests decisions made by attorneys or deputies is available via this policy:

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/recording-a-best-interest-decision-made-by-a-relevant-attorney-or-court-of-protection-deputy-accessible.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/recording-a-best-interest-decision-made-by-a-relevant-attorney-or-court-of-protection-deputy-accessible.docx)

**Practice note**

It is important that a record is kept when professionals are aware of a best interest decision being made by a relevant attorney or Court of Protection (CoP) deputy. Professionals must be satisfied that the person making the decision has the correct legal authority to do so and is abiding by the MCA codes of practice. Don’t forget to take and store a copy of the relevant document (attorney document or CoP order) and check that the power is valid and has been granted for the decision in question. Should professionals ever have concerns with regards to the decision process, it is vital that those concerns are raised and acted upon in an appropriate and timely manner.

* **When to use this form, which decisions?**All decisions professionals are involved in and aware of where there is potential for a legal challenge. More complex decisions, such as (but not limited to) care packages, accommodation/ change in residence, health/ treatment decisions, significant financial decisions such as selling a property.
* **When should the best interest decision be reviewed/revisited?**

As and when professionals are made aware of any changes to the circumstances which impact on the best interest decision made. This could include new viable options, an increase to restrictive care being provided, change in level of need, a conflict or disagreement etc.

* **Who is responsible for filling this out?**

Best practice would be for the professional who has had the discussion with the attorney/CoP deputy and who completed the associated capacity assessment.

* **Where do we keep this record?**

On the person’s Systm One record for those organisations which use this and/ or in the person’s care files. Please also ensure that a copy of the relevant power is uploaded to Systm One and/ or the person’s care file.

* **How to respond to any concerns raised by the decision made**Clearly record the decision maker as the appointed person. Support the appointed decision maker by working through the best interest checklist; this could be in the form of a best interest meeting. If you continue to have any concerns:  
  a) Consider the appointment of an advocate for the person about whom the decisions are being made (even when none of the statutory triggers apply, an advocate for the person could help to ensure their voice is heard, in their best interests)  
  b) Consider mediation in situations where they may be a dispute  
  c) Consider whether a referral to the Safeguarding Adults Team (Focus) and/or the Office of Public Guardian is appropriate if you are concerned that the decision maker may not be acting in the individual’s best interests  
  d) As a last resort apply to the Court of Protection if challenge/conflict/concern cannot be resolved any other way

**Decision resulting in a deprivation of liberty (DoL):** If any decisions being made trigger consideration of the acid test, please follow the current DoL Safeguards or parallel CoP procedures. If/ when the Liberty Protection Safeguards (LPS) are implemented, please follow the LPS process; this means applying for an authorisation in advance of the deprivation taking place when such is planned. Attorneys and CoP deputies are *UNABLE* to authorise arrangements amounting to a deprivation of liberty.

## APPENDIX G - Prescription and Administration of Medication without Consent

The following guidance is available via this policy:

* Guidance for staff within acute settings

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-acute-staff-may-2023-accessible.docx>

* Guidance for General Practitioners

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-gps-may-2023-accessible.docx>

* Guidance for non-medical prescribers

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-non-medical-prescribers-may-2023-accessible.docx>

* Guidance for mental health prescribers

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-mental-health-prescribers-may-2023-accessible.docx>

* Guidance for providers

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-providers-april-2021-accessible.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-providers-april-2021-accessible.docx)

* Guidance for signatories

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-signatories-april-2021-accessible.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/guidance-for-signatories-april-2021-accessible.docx)

The following condition has been created for use within a deprivation of liberty authorisation, and is available via this policy:

[www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/conditions-june-2021-accessible.docx](https://www.northeastlincolnshireccg.nhs.uk/data/uploads/mca-dols/conditions-june-2021-accessible.docx)

## APPENDIX H – practice guidance on Adult Refusals of Care and Treatment

The following guidance is available via this policy:

[Link to practice guidance on Adult Refusals of Care and Treatment](https://portal.yhcs.org.uk/documents/5665646/5922590/Practice+Guidance+Adult+Refusals+of+Care+and+Treatment/95317bdb-72a2-434d-8277-6c2e1ed099b5)

## APPENDIX I - MCA Commissioning Standards

The following standards have been developed locally to support the Partners in monitoring and assessing the quality of the services and support they commission or provide. These standards are based on best practice identified by the Social Care Institute for Excellence. Care Delivery Partners may also wish to use these standards as part of their own quality management processes.

Beneath each standard is a list of the types of evidence that would demonstrate whether or not that standard is being achieved. These prompts represent suggested areas for enquiry which can be used to build tools for reviewing practice/ delivery.

*Commissioning Standard 1*

Services and support deliver person-centred, rights-based care that promotes the person’s wellbeing.

Care plans should incorporate:

* the person’s preferred style of address;
* what the person would like to achieve from their care and support, their goals and aspirations for the future;
* what is important to the person about their lifestyle, what they enjoy, dislike, etc.;
* any other specific lifestyle choices that may affect the way their care and support are provided – for example, sexual orientation, spiritual rituals, special diets, etc.;
* historical and social information to help staff get to know the person better, such as their family circumstances, social situation, significant events past and present, key achievements;
* any statement of wishes or future preferences for their care and support should they lose capacity to express these (including end of life wishes);
* any advance decision to refuse treatment.
* details of the person’s ability to consent to care arrangements or, if they are unable to consent, details of compliance with the best interests checklist

*Commissioning Standard*

The needs and wishes of the person are at the centre of their care and support package/plan.

Care plans should:

* demonstrate how to communicate with the person, whether the person has any special communication needs, and how these needs can be understood and met;
* incorporate information about who is important to the person and the level of their involvement – for example, family member or a friend who helps with shopping;
* include details of any attorneys (lasting or enduring);
* provide details of anyone else the person wants to be involved in decisions about their care and support and the information that can be shared with each named person;
* clarify how the person and their chosen representative are involved in the care planning arrangements;
* details of the person’s ability to consent to care arrangements or, if they are unable to consent, details of compliance with the best interests checklist

*Commissioning Standard 3*

Care and support is commissioned and delivered in a way that promotes the individual’s rights, whilst protecting the person from risk.

Care plans should:

* The contract, between the Partners and key Care Delivery Partners, should stipulate that the provider must submit evidence of compliance with the following, to the commissioning Partner (frequency to be determined):

Table 3: evidence requirements

|  |
| --- |
| Policy on consent   * MCA and MCADoLS policies in place and acted on; * Appointment and update on the impact of the MCA Lead; * Evidence that the capacity assessment and best interests checklist have been incorporated into the care planning process; * Evidence that the persons rights and wishes are mapped to the care planning process; * Evidence that the MCA has been incorporated into the providers systems and processes.   Training   * Assurance that MCA is incorporated in job descriptions; * Evidence of compliance with the MCA and MCADoLS Codes of Practice.   Supported Decision Making   * Evidence how staff support patients to make their own decisions; * Evidence how the provider involves the persons family in decision making process.   Advocacy   * Activity update, highlighting on number of referrals for Serious Medical Treatment and Safeguarding Adults; * Evidence that the IMCA service is incorporated within all relevant provider policies.   Rights and Freedoms   * Evidence that the rights to family life and freedoms are reflected in the patients care plan (Evidenced via the best interests checklist).   Governance   * Evidence that the provider submits formal update reports, on compliance with the MCA and MCADoLS, to the Trust Board; * Evidence that the MCA is incorporated in the providers audit plan and governance processes; * Evidence that the provider is up to date on relevant case law, relating to the MCA.   Advance Decision Making   * Evidence that staff understand their roles and responsibilities in relation to advance decisions. |

Care plans should move away from a paternalistic approach to care management and manage the person care in a way that enables and empowers the person to make informed decisions and, in some cases, take positive risks.

Care plans demonstrate that additional safeguards are in place when a person is either restrained or deprived of their liberty. The challenge for providers and commissioners is to manage the tension between promotion of rights and protection from risk.