GLOUCESTERSHIRE MULTI AGENCY MENTAL CAPACITY ACT POLICY

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Originator/author: [redacted], MCA Governance Manager

Executive lead: MCA Governance Manager

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REVISIONS HISTORY

Issue Number	Date	Author(s)	Principal Changes
1	March 2006	GCC Policy and Planning Group [redacted]	• Original GCC policy.
2	March 2007	GCC Policy and Planning Group [redacted]	• Up-date of original policy to take account of implementation guidance. Noted some changes were still in development.
3	09/05/2011	[redacted] [redacted] (seconded from 2gether NHSFT as MCA and MHA Implementation Manager)	• Development of the original policy into a multi-agency policy, procedure and guidance • Introduction of a specific MCA2 (FACE form) for significant mental capacity assessment decisions, plus associated guidance • Introduction of sections on CQC, quality and accountability, Advance Decisions, restraint/DoLS, finance, consent, covert medication, interface with the MHA, the ambulance service, police service, research, CYP, carers and personalisation.
4	September 2013	[redacted] [redacted] Independent Consultant on	• Revised in the light of implementation and particularly the 2012 MCA2 audit across GCC and 2gether NHSFT

		behalf of GCC and MCAGG	• **New sections on Day to Day Decision Making, Fluctuating Capacity and Review of Capacity Assessments, (GSAB recommendation), Assessor Qualification, Summary of Key Legal Judgements, MCA2 Audit policy implications and the BME Community** • **New appendices on Day to Day Decision Making (1.1-1.7) Practice Guidance on Accessing the Court of Protection, Best Interests Meetings Guidance, Best Interests Decisions at the End of Life, MCA Performance Management Framework, MCA2 Audit**
5	**August 2019**	[redacted] **MCA Governance Manager and MCAGG**	• **Revised and updated.**
6	**September 2023**	[redacted] **MCA Governance Manager and MCAGG**	• **Revisions to assessment of capacity and introduction of new MCA Assessment form and Best Interest form.**

CONTENTS

1. INTRODUCTION

1.1 The Mental Capacity Act (MCA) 2005 provides a statutory and quality framework to empower and protect people over the age of 16 who lack capacity to make decisions for themselves. It makes it clear who can take decisions, in which situations and how they should go about this in respect of people who lack capacity to make particular decisions for themselves.

1.2 The Act enshrines in statute principles concerning people who lack mental capacity and those who take decisions on their behalf. It puts a legal and statutory framework for decisions around capacity and Best Interests providing legal protection for staff and others, and protection for people who lack capacity by setting out a mandatory procedure for making decisions on their behalf. It provides three fundamental powers in relation to health and social care decisions;

- an opportunity for people who have capacity to plan for a time when they may lack capacity (Lasting Power of Attorney - LPA)

- a legal framework for people with capacity to record their wishes for future treatment, especially the refusal of treatment (Advance Decision - AD) and

- a legal framework for staff and others to make a Best Interests decision on behalf of another person.

2 GLOUCESTERSHIRE MCA GOVERNANCE GROUP (MCAGG)

2.1 The MCA Governance Group (MCAGG) provides a focus on governance. Membership consists of senior health and social care MCA leads from Gloucestershire's statutory health and social care organisations and the Provider Sector. Healthwatch Gloucestershire is also represented.

2.2 The MCAGG's vision is 'To work in partnership across Gloucestershire's health and social community to empower and protect the rights and liberties of Gloucestershire's most vulnerable citizens through embedding the MCA in day to day practice'

2.3 The overall aim of the MCAGG is to lead implementation of the MCA in Gloucestershire ensuring good practice and a coherent approach across organisations within the MCAGG vision. Terms of reference can be found on the GCC MCA website www.gloucestershire.gov.uk/MCA.

2.4 This Multi-Agency Policy, Procedure and Guidance have been developed on behalf of the MCAGG.

2.5 The MCAGG reports to the MCA Strategy Group, which reports to the Joint Commissioning Partnership Executive.

3. SCOPE:

3.1 This policy applies to health and social care staff that are represented on the Gloucestershire MCAGG. It is recognised that partner agencies may have developed or need to develop further specific MCA procedures and guidance to meet the needs of their particular context and function, within the framework of this overarching policy. This policy must be read in conjunction with any agency specific policies and procedures.

The Act generally applies to people aged over 16 years of age.

4. Statement of Commitment

The Gloucestershire MCAGG and its partner Agencies are committed to ensuring that people who use Gloucestershire services and who lack mental capacity to make decisions are provided with high quality care from a knowledgeable and competent workforce. This Policy and the following procedures aim to ensure that staff understand the requirements of the MCA and are able to comply with their legal duties.

5. Key Principles

Staff must be aware and mindful of the five principles that underpin the legal requirements of the MCA.

The 5 principles are summarised below:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable (doable) steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- Any action done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the action 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.

6. Assessment of Capacity

6.1 <u>The assessment of capacity is central to the MCA</u>.

Before considering whether a person's capacity requires assessment, there must be some reason to trigger the view that capacity is in question. The first principle of the MCA is to assume that a person has capacity. It is for an assessor to evidence why capacity is in question. While the MCA requires that a lack of capacity cannot be assumed because of a person's age, illness or appearance, changes in behaviours may lead you to consider whether capacity is in question.

Example:

Mrs Williams has been known to take pride in her appearance. Recently she has been seen looking unkempt. She has been showing signs of confusion and has problems with continence. None of those factors can lead a professional to conclude that Mrs Williams lacks capacity around any decision, but it may trigger thoughts that capacity around daily care or personal hygiene should be explored.

The Act sets out the test for assessing whether a person lacks capacity to make a particular decision at a particular time.

6.2 <u>What is capacity?</u>

Capacity is the ability to make a decision.

The MCA defines a lack of capacity as:

"*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of a an impairment of, or a disturbance in the functioning of the mind or brain*." (Include reference – MCA S2 (1); Code of Practice 4.3).

This means that a person lacks capacity if:

- they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works,
  and

- the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

6.3 <u>Capacity is time and decision specific</u>. An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

6.4 <u>When to assess?</u>

Firstly there must be a decision which needs to be taken.

When there is a doubt about a person's capacity an assessment should be carried out. (MCA CoP 4.4).

There are a number of reasons why people may question a person's capacity to make a specific decision:

- the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision,
- somebody else says they are concerned about the person's capacity, or
- the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.

6.4 Day to Day and Significant Decisions

There is a distinction between day to day decisions and "significant decisions".

6.4.1Day to day decisions can be broadly grouped within provision of health and social care within the following headings:

- Personal care needs
- Social needs
- Nutritional needs
- Safety needs
- Treatment needs
- Everyday finances.

6.4.2 A significant decision is being made if there are concerns that an individual may not have the capacity to:

- Consent to '*Serious Medical Treatment'* (see Section 6.15 – 6.19, MCA Code of Practice. Real examples of SMT include '*smear tests'*, hip replacements/resurfacing, any treatment requiring a general anaesthetic, someone with breast cancer refusing treatment, blood test with serious implications, operation for a cataract etc.
- Consent to an informal admission (to hospital, nursing or care home)
- Consent to a change of accommodation
- Manage their property or financial affairs, health or welfare
- Consent to their confidentiality being breached – e.g. during a S42 enquiry
- Make complex safety decisions e.g. GPS tracking devices
- Participation in court proceedings e.g. Family Court, High Court, whether as an individual or a parent.

The above list is not exhaustive and professional judgement must be used.

6.5 Who should assess?

The MCA stipulates that the person who assesses capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. A decision regarding a medical treatment will be for the medical professional, e.g. GP or consultant, to take. A decision on a care placement will be for social work professionals to take. It is important to remember professionals working with a person, with expertise in that particular area should not expect other professionals to assess capacity for that particular decision.

In practice this means that family members and informal carers are responsible for assessing capacity when a decision needs to be made about day-to-day care, such as what clothes to wear on a particular day. The MCA does not require family members and informal carers who provide day-to-day care to undertake a formal capacity assessment each time they deliver care. Instead, they need to have 'reasonable belief' that the person lacks capacity for the specific decision.

For formal carers, they should record the capacity assessment into the person's records. The more complex the decision, the greater the expectation there is of more robust recording of the capacity assessment.

Professionals are responsible for assessing capacity for actions they are proposing. This means, for example, that a nurse will be responsible for assessing a person's capacity to consent if they are proposing a particular treatment or intervention, and a social care professional will be responsible for assessing a person's capacity if a decision needs to be made about a move into residential care.

A Court of Protection Deputy or Lasting Power of Attorney may be responsible for assessing capacity for decisions that fall within the scope of their authority.

Assessing capacity

• Anyone assessing someone's capacity to make a decision will need to apply the test in the Act. It can be broken down into three questions:

- Is the person able to make the decision (with support if required)?
- If they are unable, is there an impairment or disturbance in the functioning of their mind or brain?
- Is the person's inability to make the decision because of the impairment or disturbance?

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

- **understand information about the decision to be made ('relevant information')** *this includes the nature of the decision, the reason why the decision is needed and the likely effects of deciding one way or another, or making no decision at all,*),
- **retain that information in their mind (long enough to make the decision),** *a person must be able to hold the information in their mind long enough to use it to make a decision. It does not matter that they could not remember the information prior to the discussion or remember it afterwards, but they do need to be able to keep key pieces of information in their mind at one time, in order to be able to weigh them up*
- **use or weigh that information as part of the decision-making process**, *in addition to understanding relevant information, people must have the ability to weigh it up and use it to arrive at a decision. Sometimes an impairment or disturbance may cause a person to inevitably arrive at one decision. Although they understand the information, they cannot use it as part of the decision making process,*
- or
- **communicate their decision (by any means).**
  Communicating a capacitated decision is different from a persons being able to extress a view or a wish. If a person cannot Understand, Retain or Weigh up the relevant information for a decision they will not be able to communicate a capacitated decision.

6.7 Temporary or Fluctuating Capacity

The MCA Code of Practice makes specific reference to people with fluctuating or temporary capacity. The assessor must consider whether the person's lack of capacity is temporary. This might be due to the effects of drug or alcohol use, or acute illness e.g. a person with a psychotic illness may have delusions that affect their capacity to make decisions at certain times but not at other times; a urinary tract infection can cause a person to temporarily lose capacity to make decisions. What is relevant is the person's ability to make a specific decision at a specific time. In cases of temporary or fluctuating capacity, staff must consider whether it is possible to postpone the specific decision until a later date when a person might have capacity to make it. In an urgent situation, it might not be possible to postpone the decision. Staff must then ensure that they review the person's capacity to make the decision at a suitable future date.

6.8 Duty to Support Decision Making

Following principle 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."*

Before reaching the conclusion that a person lacks capacity to make a specific decision, it is the responsibility of staff to do everything they can to enable the person to have the best chance of making their own decision. This would involve asking the following questions:

- Does the person being assessed have all the relevant information they need to make the decision?
- If they are making a decision that involves choosing between alternatives, do they have information on all the options?
- Would the person have a better understanding if information was explained or presented in another way?
- Are there times of day when the person's understanding is better?
- Are there locations where they may feel more at ease?
- Can the decision be put off until the circumstances are different and the person concerned may be able to make the decision?
- Can anyone else help the person to make choices or express a view? (for example, a family member or carer, an advocate or someone to help with communication) (MCA code of practice:4.36).

If a person can be assisted to make the decision themselves, professionals will not be required to consider further actions under the Mental Capacity Act for that decision.

6.9 When to Involve Other People

It may be appropriate and necessary for the person assessing capacity to enlist the help of others. For example, a social care professional assessing a person's capacity to make decisions about their care needs when being discharged may need to seek an opinion from family and friends, ward staff, or anyone with knowledge of the person. The assessor may also need to ask for an opinion from a professional who has specialist training or knowledge about a particular condition or disorder. For example, a Speech & Language Therapist might be able to help if there are communication difficulties; or a clinical psychologist specialising in learning disabilities might be able to offer an opinion about a person's understanding.
The final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity, and not the professional who is there to advise.

6.10 Burden of Proof

Capacity assessments are decided on balance of probabilities. In practice, this means deciding whether, on balance, the individual is more likely to have capacity or more likely to lack capacity to make the decision.
A Capacity assessment is not some kind of scientific process where capacity is measured; it's a conversation and a value judgement for the person assessing capacity. It is important that professionals record the evidence and the outcome of a capacity assessment in the person's notes or records.

6.11 What Happens When the Assessment is completed?

If the assessor concludes that the person has capacity to make the decision or could be supported to make the decision themselves, no further action can be taken under the MCA.

If the conclusion is that the person lacks capacity to make the decision then a decision will need to be made in the person's best interests.

The assessment should be recorded into the person's records

6.12 Refusal to be assessed

There may be circumstances in which a person whose capacity is in doubt refuses to undergo an assessment of capacity. The code of practice makes it clear that nobody can be forced to undergo an assessment of capacity and if someone refuses to open the door to their home, it cannot be forced.

There are a number of steps that should be considered if a person refuses to engage in the assessment:

- If applicable, re-allocate to another social care or health professional,
- Consider whether anyone else can facilitate access. This might be a friend neighbour, family member or other professional, who the person engages with,
- Consider whether there is another professional that the person engages with and who, so they could give an opinion about the person's capacity,
- Consider whether there is an alternative venue. For example, a GP surgery or day centre.

If all attempts to engage the person fail, it will be necessary to gather evidence about the person's capacity from:

- Anything they have written which gives insight into their capacity to make the specific decision,
- Any witness who can give information about the person's capacity to make the decision in question. This could be from family, friends, neighbours, or professionals.

If it has not proved possible to engage with the person, the assessor can make an assessment of capacity based on this evidence.

7. **Best Interests**

When it is established that an individual lacks capacity to make a particular decision, the MCA requires 'best interests' as the criterion for any action taken or decision made on that person's behalf. It should not be the personal views of the decision maker. Instead it considers both the balanced approach of the pros and cons of the options available for the person and decides what course of action is, on balance, the best course of action for them.

7.1 Who is the decision-maker?

The person who decides what is in a person's best interests is referred to in the MCA as the 'decision-maker'. The decision maker is the person who is proposing to take action in relation to the decision.

Under the MCA, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions themselves in relation to certain things:

For most routine decisions, this will usually be the person caring for, or supporting the person on a day to day basis

For medical interventions, it would be the Doctor or whoever is responsible for carrying out the particular treatment or procedure

For social services care plans, the best interest's decision maker will be the relevant social care professional

An LPA or deputy will be decision maker within the scope of their authority

7.2 How does the decision-maker decide what is in a person's best interests?

There is no definition of 'best interests' in the MCA. Instead, s.4 of the MCA sets out a 'checklist' of factors that the decision maker must apply when determining what is in a person's best interests (See Appendix 5 The Best Interests Checklist). Staff must follow this checklist when making a best interests decision:

- Encourage Participation - Make every effort to permit and encourage the person to participate in the decision to be made:
- Identify all relevant circumstances - Identify all the relevant issues and circumstances relating to the decision in question:
- Find out the person's wishes, feelings, beliefs and values, past and present:
- Avoid discrimination - the decision must not be made merely on the basis of the person's age or appearance, race, religion, sexuality or sex. Show equal consideration and non discrimination,
- Assess whether the person might regain capacity and if so, whether the decision can be delayed,
- If the decision concerns life-sustaining treatment, staff must not be motivated in any way by a desire to bring about the person's death,
- Consult others: including family and other professionals,
- Avoid restricting the person's rights - the decision maker must assess whether there is a less restrictive option,
- Take all of this information into account when deciding on the best interest decision.

If there is serious disagreement between the decision maker and the person/family members, seek legal support with a view to consideration of a referral to the Court of Protection.

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8. Consultation and further advice

8.1 All staff should be familiar with the Mental Capacity Act (2005) and the Code of Practice (2007) and have access to their manager should they have any concerns. All managers are expected to have a good level of awareness with regard to the MCA, regardless of how often they are using the Act and must be able to support their staff where appropriate.

8.2 Where consultation or guidance is required or sought regarding an assessment of capacity or Best Interest's decision, this should be sought from the staff member's line manager, an experienced colleague, named MCA Champion or MCA Organisational Lead. Staff could also take advice from the multi-agency MCA Governance Lead (MCAGL) and / or their organisations legal support services.

9. Quality, performance and accountability

9.1 One of the strategic aims of the MCAGG is '*To promote compliance and provide performance information on the MCA in order to achieve full implementation across all appropriate areas in line with the multi-agency MCA policy*'.

9.2 All agencies within Gloucestershire including GCC, ICB, Health Trusts (GHNHSFT and GHCNHSFT), private hospitals, care homes and nursing homes should identify a named MCA Organisational Lead who will be responsible for defining, promoting and monitoring the quality and efficacy of the services provided to adults who may lack capacity. They should have access to their organisations legal advice provider.

9.3 The named MCA Organisational Lead will provide a contact point for other agencies.

9.4 The named MCA Organisational Lead is responsible for linking into the wider Gloucestershire MCAGG to share information and provide specialist advice to the group or where required other agencies in respect of services or information provided by the agency. They may also be their agencies MCAGG representative.

9.5 Agencies with a variety of operational bases should ensure that all teams and units have a named MCA Champion within all teams and units to act as a local source of expertise on the MCA.

9.6 Individual assessments of capacity are the responsibility of every health and social care practitioner. The individual clinician has accountability and responsibility to ensure the quality of their assessment in line with professional codes, professional guidance and organisational policy.

9.7 All assessments of an individual's capacity must be recorded in the individual's case notes and or on the appropriate agency electronic system. A format for recording such assessments is included in the Appendices; Forms **MCA1** (day to day decisions) and **MCA2** (significant decisions). For a visual representation of the referral process see the **MCA flow chart**.

9.8 GCC, NHS Trusts and other agencies in Gloucestershire will quality assure their own MCA2 or equivalent assessments.

10. Independent Mental Capacity Advocates (IMCA)

10.1 An IMCA is someone appointed to support a person who lacks capacity and has no one to speak for them, such as family or friends. There is a statutory duty to appoint an IMCA where the decision is any of the following:

- Change of Accommodation**:** An IMCA must be instructed where a decision is proposed about a move to or a change in accommodation where the person lacks capacity to make the decision and there are no family or friends who are willing and able to support the person. This includes moving to a care home for 8 weeks or more, or admission to hospital where admission is likely to last 28

days or more.

- Serious Medical Treatment**:** NHS bodies must instruct and then take into account information from an IMCA where decisions are proposed about *'serious medical treatment'* where the person lacks the capacity to make the decision and there are no family or friends who are willing and able to support the person.
- Safeguarding Adults**:** LAs have statutory duties under the Care Act 2014 to instruct and must consider an IMCA to support and represent a person who lacks capacity where there is:
    - •a safeguarding enquiry
    - •a safeguarding adult review
- Care Reviews: A responsible body can instruct and must consider an IMCA to support and represent a person who lacks capacity when:
    - they have arranged accommodation for that person
    - they aim to review the arrangements (as part of a care plan or otherwise)
    - there are no family or friends whom it would be appropriate to consult.
- Deprivation of Liberty Safeguards (DoLS): DOLS provides legal protection for vulnerable people who may be deprived of their liberty in a hospital (other than under the Mental Health Act 1983) or care home, whether placed there under public or private arrangements. In certain circumstances, a person who is unbefriended and has no one to represent their interest and views must have an IMCA instructed to support them. The DoLS Code of Practice provides details of when an IMCA should be instructed.

10.2 The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

11. Advance Decisions

11.1 The MCA created statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they lack capacity in the future.

Where an Advance Decision concerns life sustaining treatment certain formalities must be complied with:

- the decision must be in writing,
- it must be signed and
- it must be witnessed.

Where an individual has an Advance Decision, which relates to life sustaining treatment and the formalities have been complied with, it must be complied with.

11.2 Documentation and guidance for individuals in respect of Advance Decision

making is set out in Appendix 7

12. Deprivation of Liberty

The DoLS Webpage and details of the referral process can be found at https://www.gloucestershire.gov.uk/media/2085835/gcc-dols-policy-2018-working-draft.pdf

12.1 The Deprivation of Liberty Safeguards (DOLS) come under the MCA. The MCA remains the over-arching legislation and anyone implementing this policy must also adhere to the duties set out in the MCA. The DOLS apply to residents in care homes or hospitals where they meet the acid test as set out in the Cheshire West case[1]. Where the person lacks capacity to consent to being accommodated for the purposes of care or treatment, there are two key questions to ask:

- Is the person subject to continuous supervision and control?
- Is the person free to leave? (in the sense of removing themselves temporarily or permanently in order to live where and with whom they choose).

12.2 Residents in community settings, e.g. Supported living, are deprived of their liberty if they meet the "acid test". Only the Court of Protection can authorise deprivations in community settings. Seek legal support where necessary.

The Court of Protection also provides a process to allow anybody deprived of their liberty the right of access to a court, which will review the lawfulness of their deprivation of liberty.

Note: The Governments plan to introduce the Liberty Protection Safeguards to replace the DoLS Regulation, have been delayed "beyond the lifetime of this Parliament" (announcement made in April 2023).

13. The Court of Protection

13.1 The Court of Protection exists to safeguard vulnerable people who lack the mental capacity to make decisions for themselves. These decisions may relate to the person's finances or their health and welfare. The CoP is responsible for:

- deciding whether someone has the mental capacity to make a particular decision for themselves
- appointing deputies to make ongoing decisions for people who lack mental capacity
- giving people permission to make one-off decisions on behalf of someone else who lacks mental capacity

[1] *(P (by his litigation friend the Official Solicitor)(Appellant) v Cheshire West and Chester Council and another (Respondents)P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council(Respondent)*

- handling urgent or emergency applications where a decision must be made on behalf of someone else without delay
- making decisions about a lasting power of attorney or enduring power of attorney and considering any objections to their registration
- considering applications to make statutory wills or gifts
- making decisions about when someone can be deprived of their liberty under the Mental Capacity Act.

If you consider that an application to CoP is necessary seek legal support.

14. Interface with The Mental Health Act 1983

14.1 Professionals may need to think about using the MHA to detain a person and treat their mental disorder if they lack capacity to consent to treatment (rather than use the MCA), if:

- it is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty
- the person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
- the person may need to be restrained in a way that is not allowed under the MCA
- it is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- the person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- there is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

14.2 If the person is a resident anywhere other than in a Mental Health Hospital, before making an application under the MHA, decision-makers should consider whether they could achieve their aims safely and effectively by using the MCA instead.

15. Professionals Protection for acts Done Under Section 5 MCA

14.1 Staff will be protected when they have not gained consent for the course of action in connection with care and treatment (apart from restraint: see below) as long as they:

- take ‘reasonable steps’ to determine whether the person lacks capacity to consent to the action and document in to the person records
- have a reasonable belief that the person lacks capacity in that context
- Have considered the Best Interests of that person and are acting within the Five Principles of the Act (see 1.4 above)
- Do not contravene the wishes of an LPA or Deputy, or a valid and

applicable Advance Decision to Refuse Treatment

15.2 This protection is limited to undertaking acts without the consent of a person. It does not protect against the 'standard' liability for loss or damage or negligence – either in carrying out a particular act or by failing to act where necessary.

15.3 If there is serious disagreement among decision-makers, despite IMCA referral and case meetings, referral to the Court of Protection for a Best Interests decision may be necessary.

15.4 Healthcare and treatment

The Code of Practice distinguishes between urgent treatment and treatments with serious implications which require special consideration. The courts will be supportive of healthcare professionals who act in good faith to treat people lacking capacity in urgent situations, unless those professionals are aware of clear reasons why the treatment should not be given. The courts will expect professionals to have considered capacity and best-interests in line with the MCA and Code of Practice in managing people who lack capacity and in whom treatments with serious implications are being considered.

15.5 Restraint

The Act defines restraint as 'using (or threatening to use) force to do an act which the person resists' or 'restricting the liberty of movement of someone who lacks capacity whether or not the person resists'. Restraint can be verbal or physical (for example, threatening a person with an action, holding them down, locking them in a room, or sedating them).

The Act allows a limited degree of restraint when carrying out care or treatment only if there is reasonable belief that it is necessary to prevent harm to the person. The restraint must be proportionate to the likelihood and seriousness of harm.

Restraint (or restriction) should not be frequent, cumulative or on-going since this may amount to a Deprivation of Liberty (DoL). The Deprivation of Liberty Addendum to the Mental Capacity Act (April 2009) requires that specific authorisation be sought by any individual or organisation restraining or restricting a person in such a way as to deprive them of their liberty.

16 **Transport**

16.1 Health and social care professionals and police and ambulance personnel need to take reasonable steps to ascertain capacity to consent and make a best- interests decision as to transport. In general it is lawful to convey people who lack capacity as long as it is done to prevent harm and that it is proportionate to the seriousness of harm (the expectation of prior assessment is lower in urgent or emergency situations).

People cannot be transported for treatment if they have made a valid and applicable advance decision to refuse treatment.

Health and safety considerations, lone working, insurance provision and appropriate risk assessments continue to have primacy when transporting vulnerable people.

Informal Carers can convey a person without specific consent as long as they have taken reasonable steps to ascertain that the person lacks capacity to agree to be conveyed, and that it is in their best interests to be conveyed.

17. Young people and Mental Capacity

17.1 Within the MCA 'children' refers to people aged below 16 while 'young people' refers to people aged 16 &17. This section should be read in conjunction with Chapter 12 of the MCA Code of Practice 'How does the Act apply to children and young people'.

17.2 The Act does not generally apply to people under the age of 16 with the exception of offences of ill-treatment or wilful neglect and the Court of Protection's power to make decisions about a child's property or finances where the child lacks to capacity to make such decisions and is likely to still lack capacity to make such financial decisions when they reach the age of 18. The former only applies if the child's lack of capacity to make a decision for themselves is caused by an impairment or disturbance that affects how their mind or brain works and not due to the child's youth or immaturity when it would be dealt with under the separate offences of child cruelty or neglect. Care and treatment of children under the age of 16 is generally governed by common law principles. The Deprivation of Liberty Safeguards (DoLS) only applies to people aged 18 years and over.

17.3 The general rule is that the person or people who have parental responsibility for the young person who lacks capacity should make the decision (MCA Code of Practice 12.16). They should follow the principles of the MCA and act in the young person's Best Interests.

17.4 What is the "zone of parental control"?
There are two key questions. First, 'is the decision one that a parent would be expected to make, having regard both to what is considered to be normal practice in our society and to any relevant human rights decisions made by the courts'? Second, 'are there no indications that the parent might not act in the best interests of the child or young person'?

17.5 If the decision does not come within the zone of parental control it will be necessary to use MCA processes instead. This will be, for instance, if the proposed treatment is particularly invasive or controversial, or if the young person is resisting, or if the interests of the parents conflict with the Best Interests of the young person.

17.6 The decision maker will need to assess the young person's capacity and Best Interests. Following the Best Interests checklist (the decision maker will need to consult people involved in the care and support of the young person, which will include, but not be limited to, people who have parental responsibility plus grandparents, doctor and education representatives. An IMCA should be involved where the child or young person has no-one else (other than paid staff) to represent them, or there are child

protection concerns. Care should be taken during this process to protect the young person's right to confidentiality.

17.7 The Court of Protection can make determinations about a young person's capacity or a Best Interest decision. This should only be used as a last resort.

17.8 **CONSENT TO CARE OR TREATMENT**:

Chapter 12 'How does the Act apply to children and young people?' of the MCA Code of Practice 12.11-22 and Chapter 3 'Children and young people' of the DoH 'Reference guide to consent for examination or treatment' (July 2009) provide information including consent of young people aged 16 &17, children under the age of 16 years and the concept of Gillick competence, a child or young person with capacity refusing treatment, a child lacking capacity and research. The following is a summary of key points:

Young people 16 &17 years old are presumed to have capacity/to be competent to consent to surgical, medical or dental treatment and to associated procedures, such as nursing care (Family Law Reform Act 1969, Sec 8 (1)). However, unlike adults, the refusal of a competent person aged 16 &17 years may in certain circumstances be overridden by either a person with parental responsibility or a court (see para's 13-18 of Chapter 3 'Children and young people' of the DoH 'Reference guide to consent for examination or treatment' (July 2009). 'But, once children reach the age of 18 years no-one can take decisions on their behalf.

To give valid consent a young person must:

- Have the capacity/competence to consent to the particular decision being considered (competence may vary depending on the nature of the decision, must be assessed for each decision and may fluctuate
- Have sufficient information to make the decision; and
- Not be subjected to any undue influence when making their decision.

If the 16 &17 year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however good practice to involve the young person's family in the decision-making process – unless the young person specifically wishes to exclude them.

Unlike 16 &17 year olds, children under the age of 16 years are not automatically presumed to be legally competent to make decisions about their care/treatment. The concept of Gillick competence rather than the MCA capacity test applies to under 16s. In the case of Gillick, the court held that children who have sufficient 'understanding and intelligence' to fully understand what is involved in a proposed intervention will also have the capacity to consent to that intervention (Gillick v West Norfolk and Wisbech AHA (1986) AC 112). A child of under 16 may be (Gillick) competent to consent to medical treatment, research, donation or any other activity that requires their consent. In other words there is no specific age when a child becomes competent

to consent to treatment; it depends on both the child and the seriousness of what is proposed.

Some rarer type procedures (e.g. organ donation or other procedures which are not therapeutic for the young person (16 &17 years)) or research are not covered by the Family Law Reform Act 1969, but by the test of 'Gillick competence' – testing whether the young person is mature and intelligent enough to understand a proposed treatment or procedure (12.12 MCA CoP).

The person proposing any treatment or care must be clear about the young person's capacity to make the decision. If the young person cannot make the decision because of an impairment of or disturbance in the functioning of the mind or brain then the assessment and process of MCA will apply to the decision.

Under the common law, a person with parental responsibility for a young person is generally able to consent to the young person receiving care or medical treatment where they lack capacity under section 2(1) of the Act. They should act in the young person's best interests. However, if the young person lacks capacity to make care or treatment decisions, health or social are staff can carry out treatment or care with protection from liability whether or not a person with parental responsibility consents (12.17 MCA CoP). Alternatively the decision could be made by the person having parental responsibility. The method by which the decision is made will depend on whether the decision is in the 'zone of parental control' and who is exercising 'parental responsibility'.

If a young person has capacity to consent to treatment, their decision must be respected. If the young person makes a capacitated decision to refuse treatment this must also be respected – even if someone who has parental responsibility wishes to consent on their behalf. Where in the past courts have held that a person with parental responsibility can overrule the refusal of a Gillick competent young person it may be unwise to rely on the consent of a person with parental responsibility. If the young person has capacity, the MCA does not apply and the Court of Protection cannot intervene. The Family Courts can make decisions in such situations.

17.9 **Young People and Deprivation of Liberty**

Where a young person lives in conditions which amount to a deprivation of liberty i.e. they lack capacity, are under continuous control and supervision and are not free to leave (the "acid test"), an authorisation for the deprivation of liberty must be sought from the Court of Protection. *D (A Child) [2019] UKSC 42*. The Supreme Court held where a 16 or 17 year old lacks capacity to give their own consent to circumstances satisfying the 'acid test' in Cheshire West, and if state either knows or ought to know of the circumstances, then the child is to be seen as deprived of their liberty for purposes of Article 5 European Convention of Human Rights, and requires the protections afforded by that Article. That is so whether or not their parent(s) are either seeking to consent to those arrangements if imposed by others or directly implementing them themselves.

17.8 Where there is a dispute legal advice should be sought.

DEFINITIONS:

Adult at Risk:
A person aged 18 years or over; Who may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Advance decision:
This is a decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision. It has the same effect as a contemporaneous refusal of the specified medical treatment.

Attorney:
This is a person who has been appointed under either a Lasting Power of Attorney or (prior to October 2007) an Enduring Power of Attorney. An attorney has the legal right to make decisions on behalf of the donor, providing these decisions are within the scope of their authority.

Best Interests:
Any act done or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the MCA 2005 sets out a non-exhaustive checklist.

Carer:
A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems (based on Carers Trust definition http://www.carers.org/. Carers Gloucestershire is a Carers Trust Network partner.

Children:
Within the MCA this refers to people who are below the age of 16 years. This is different from the definition within the Children Act 1989 and the law more generally where the term '*child*' is used to refer to people aged under 18 years of age.

CQC:
The Care Quality Commission is a non-departmental public body of the UK government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations – whether in hospitals, care homes or people's own homes. Part of the Commission's remit is protecting the interests of people whose rights have been restricted under the Mental Health Act 1983.

Decision-maker:
This is a person who is responsible for deciding what is in the Best Interests of a person who lacks capacity. Who this is, is dependant on the decision that needs to be made. Sometimes this will be a professional and at other times a family member, carer or close friend.

Deprivation of Liberty:
This is a term used in the European Convention on Human Rights about

circumstances when a person lacking capacity is deprived of their liberty. There is no simple definition of deprivation of liberty. See Chapter 2 of the DoLS Code of Practice **http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act** for a more detailed understanding. Case law constantly changes and informs practice relating to deprivation of liberty.

Deputy:
This is a person appointed by the Court of Protection with legal authority to make particular decisions on behalf of the person who lacks capacity. Deputies for personal welfare (including healthcare) decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or there is no other way of settling the matter in the Best Interests of the person who lacks capacity to make particular welfare decisions.

Donor:
This is a person who makes a Lasting Power of Attorney (LPA) to appoint a person to manage their assets or to make personal welfare decisions or (prior to October 2007) an Enduring Power of Attorney.

Enduring Power of Attorney (EPA):
This is a power of attorney created under the Enduring Powers of Attorney Act 1985 (now been repealed) to deal with property and financial affairs. Existing EPAs continue to be valid that were made prior to the MCA.

Independent Mental Capacity Advocate (IMCA):
This is a person who supports and represents a person who lacks capacity to make a specific decision, where that person has no one else who can support them (exception for Safeguarding situations). They make sure that where significant decisions for a person who lacks capacity are made, that the person has independent representation.

Lasting Power of Attorney (LPA):
This is a power of attorney created under the Mental Capacity Act 2005. It enables a person (the donor) with capacity to appoint another person to act on their behalf (the donee) in relation to decisions about the donor's financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used.

Managing Authority:
The person or body with management responsibility for the hospital or care home in which a person is, or may become deprived of their liberty.

Mental Capacity:
A person's ability to make a specific decision at a specific time.
A legal definition is contained in Section 2 of the Mental Capacity Act 2005.

MCA Champion:
This may be a Team Manager, Sister, Matron or Team member who acts as a local source of expertise on the MCA. This should be someone who has completed level 3 of the MCA training pathway.

MCA Organisational Lead:
This is the named individual responsible for promoting the quality and efficacy of the services provided to adults who may lack capacity within their organisation. They should provide a contact point for other agencies and are responsible for linking into the wider Gloucestershire MCAGG to share information and providing specialist

advice to the network or where required other agencies in respect of services or information provided by their organisation.

Person:
In this policy this refers to the person who lacks capacity. It is used interchangeably with the word '*patient*' where the person is undergoing medical treatment.

Restraint:
The use or threat of force to undertake an act, which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

Safeguarding Adults Service:
This is the service provided by Gloucestershire County Council (GCC) for the purpose of safeguarding the welfare of vulnerable adults

Standard Authorisation:
This is the formal agreement to deprive a relevant person of their liberty in the relevant hospital or care home, given by the Supervisory Body, after completion of the statutory assessment process.

Statement of wishes and feelings:
A person with capacity may express their wishes and feelings about their future medical treatment, where they would choose to live, how they would wish to be cared for, in the event they lose capacity in the future. These are legally non-binding, but should be used by relevant professionals for consideration when making Best Interests decisions for a person who lacks capacity.

Supervisory Body:
A local authority, that is responsible for considering deprivation of liberty requests, commissioning the assessments, and where all the assessments agree, authorising the deprivation of liberty.

Urgent Authorisation:
An authorisation given by a Managing Authority for a maximum of seven days, which may be extended by a maximum of a further seven days by a Supervisory Body, that gives the Managing Authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

Young Carer:
A young carer is a child or young person, usually age 18 or under, who carries out significant caring tasks and assumes a level of responsibility for caring for a parent or relative who has an illness or disability or is experiencing mental distress, which would usually be carried out by an adult. A caring task is significant for a young carer when its impact is one which restricts the young person's personal, social and or educational opportunities (based on Carers UK definition).

Young Person:
Within the MCA this refers to people aged 16-17 years to whom most of the Act applies. See Section 16 of this policy for the exceptions.

Zone of Parental Control

This is not clearly defined however: there are two key questions. First, ‘is the decision one that a parent would be expected to make, having regard both to what is considered to be normal practice in our society and to any relevant human rights decisions made by the courts’? Second, ‘are there no indications that the parent might not act in the best interests of the child or young person.