

# Mental Capacity Act 2005

A Guide for Clinical Commissioning Groups  
and other commissioners of healthcare  
services on Commissioning for Compliance

April 2014

**NHS ENGLAND INFORMATION READER BOX****Directorate**

Medical	<b>Operations</b>	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

<b>Publications Gateway Reference:</b>	<b>01396</b>
<b>Document Purpose</b>	Guidance
<b>Document Name</b>	Mental Capacity Act: A guide for CCGs
<b>Author</b>	NHS England (London)
<b>Publication date</b>	April 2014
<b>Target audience</b>	CCG Clinical Leads, CCG Accountable Officers, Directors of Nursing, NHS England Regional Directors, NHS England Area Directors
<b>Additional Circulation list</b>	CCG Clinical Leads, CCG Accountable Officers, CSU Managing Directors, Medical Directors, Directors of PH, Directors of Adult SSSs, NHS England Regional Directors, NHS England Area Directors
<b>Description</b>	The guide sets out how CCGs and other commissioners should discharge their duty to ensure that the legislation, guidance and policy relating to the MCA are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised and protected.
<b>Cross Reference</b>	N/A
<b>Superseded Documents (if applicable)</b>	N/A
<b>Action Required</b>	N/A
<b>Timing/Deadlines (if applicable)</b>	N/A
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<b>Document Status</b>	
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## Purpose

The purpose of the Mental Capacity Act (MCA) Guide for Clinical Commissioning Groups (CCGs) is to provide guidance in relation to the commissioners' duty to ensure provider services are delivered in accordance with the provisions of the Act and that the rights of those who use services are promoted and protected.

Provider services, in this context, means, hospitals and other providers who deliver NHS funded care. **Throughout this document the shorthand 'hospital' applies to providers of health care services in all settings (hospitals, community, primary care, specialist care, etc)**

Although this document focuses on NHS responsibilities it goes without saying that the provisions of the Act equally apply to providers and commissioners of personal care services.

Likewise, although the audience for this document is CCGs, its advice equally applies to the commissioning of specialist services, primary care and NHS dental services etc. It therefore supports the work of NHS England Area Teams.

This document sits alongside two sister documents: 'Safeguarding and Protecting the Welfare of Children and Child Protection: Aide Memoire for Clinical Commissioning Groups' and 'Safeguarding Adults: Aide Memoire for Clinical Commissioning Groups'.

## Scope

The Guide sets out how CCGs and other commissioners should discharge their duty to ensure that the legislation, guidance and policy relating to the MCA are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised and protected.

The MCA covers England and Wales and provides a statutory framework for people who lack the capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack it in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act came into force in 2007.

The Act is supported by a Code of Practice which provides guidance and information about how the Act works in practice. The Code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves. These categories include healthcare and social care staff.

This Guide does not seek to explain the Act in great detail but rather to provide a framework to help CCGs determine whether their providers are recognising, protecting and delivering the rights the Act gives to incapacitated people and the responsibilities it places on organisations and individual members of staff.

CCGs require a high level of knowledge on the legislation across their organisation and need to know how to seek assurances from their providers that they both understand the legislation and are operating within its framework.

CCGs would not be expected to provide legal advice to service providers as they should have access to competent legal services in place already.

Glossary, reference and resource lists are provided for further guidance.

## Equality Assurance

"Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it."

## Acknowledgements

This resource was developed with contributions from members of CCGs, NHS Provider Trusts, Local authorities and commissioned by NHS England.

## 1. Executive Summary

The Mental Capacity Act is vital to good quality and effective healthcare. The Act is central to quality improvement and patient involvement. It gives rights to patients and provides essential safeguards to those that are vulnerable as well as setting out the responsibilities of those caring for them. The Act provides a framework for determining whether patients are able to make decisions for themselves and what should be done in such circumstances.

CCGs have responsibility for commissioning high quality care and treatment. An essential element of this is ensuring providers of healthcare understand the Act, apply it to practice and monitor compliance. CCGs are seeking assurance that the Act is embedded in the work of organisations with their patients.

**Fundamentally CCGs will want to ensure:**

- the Act is given a high profile and priority within the CCG
- compliance and what needs to be done to achieve this is a key part of tendering and contract award
- ongoing compliance is monitored in detail through performance review and quality monitoring processes

The Guide will help CCGs answer the following questions about their own performance and development:

- How does the Board recognise and discharge its duty in respect of the MCA?
- How does it monitor progress and activity?
- How does the CCG assess quality of care?
- How does the CCG manage and respond to incidents and exception reports?

This Guide sets out in detail how CCGs might go about achieving the above and provides a framework for determining expectations of healthcare providers and monitoring progress.

## 2. The Importance of the Mental Capacity Act

The MCA consolidates human rights law for people who may lack the capacity to make their own decisions. It promotes the empowerment of individuals and the protection of their rights. The Act is built on five statutory principles that guide and inform decision-making in respect of the estimated two million people who may lack capacity for decision-making in some aspects of their life including their health care. The MCA is the essential and required framework for both health and social care commissioners and practitioners particularly when working with people who may be unable to, permanently or temporarily, take some, or all decisions, about their care and treatment.

Through a good understanding of the Act, providers and commissioners can ensure that appropriate assessments of capacity are carried out and that decisions made on behalf of incapacitated people are in their best interests.

The Act is part of a framework within which healthcare providers should be working to ensure they respect patients' dignity and human rights. This framework includes:

- Human Rights (HRA) 1998
- Mental Capacity Act (MCA) 2005
- Disability Discrimination Acts (DDA) 1995 and 2005
- Equality Act (EA) 2010

The MCA is rights legislation. It protects the rights of all patients to take as many decisions about themselves for as long as possible. It places on staff a duty to help patients make decisions for themselves. If they cannot it sets out a clear and challenging process for determining whether patients have capacity and if they do not how decisions should be made on their behalf. The Act lays down the firm principle that because a patient cannot make a particular decision it does not automatically follow they cannot make the next one required of them.

### 3. Why the MCA is important to CCGs?

The Act is important to CCGs for three reasons:

- CCGs will wish to be assured that the services they are commissioning on behalf of local populations are being delivered in a way that both respects and applies the rights of individual patients and in particular those that are vulnerable and may not be able to take decisions on their own behalf
- In certain circumstances failure to provide care within the framework set down by the Act could be deemed to be unlawful. While the provider organisation is primarily responsible for acting within the law the commissioner could also be found to be equally liable
- As part of their authorisation process, CCGs were requested to have a lead for the MCA, supported by training and policies. CCGs may need to demonstrate to their Local Area Team how the Board has discharged this duty

Commissioners are seeking evidence of an embedded cultural shift within organisations. Clinical engagement should be rights based. Decisions should be made on the basis that patients have a right to make their own decisions and this should only be removed as the exception and only on clear evidence that the assumption of capacity be put aside and in accordance with framework set down in the Act.

### 4. The role of CCGs

This section looks at the roles and responsibilities of CCGs as commissioners of MCA-compliant services. It gives examples of the evidence CCGs could ask for from services and how the standard contract could support MCA compliance.

The Health and Social Care Act 2012 determined that CCGs take on responsibility for

commissioning the majority of local health care. All such health care has to be MCA compliant.

CCGs are required by their authorisation process to have a named responsible MCA Lead. They should also put in place policies and training. The MCA Lead has primary responsibility, on behalf of the CCG, for ensuring that it commissions appropriate health care, in compliance with the MCA, for those adults normally resident within the area who may not have the capacity to consent to treatment even if that treatment is received in another area. The CCG is responsible for ensuring that all the services it commissions for people aged over 16 demonstrate compliance with the MCA.

As part of the commissioning process, CCGs could reasonably expect to see evidence of the following from hospitals and other services providing care to adults (aged over 16) who lack capacity to consent to the arrangements for their care and treatment in hospital.

#### Policy

- Copies of service providers' MCA policies.
- Evidence that each hospital etc has an MCA lead.
- Written evidence of MCA-compliant capacity assessments and best interests decision-making documentation and procedures.
- Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning policies, guidance and training.
- Evidence that the MCA is linked into the hospital's systems and processes relating to improving service users' experience and the quality of their care and treatment.
- Policies on research recognise the rights of those lacking capacity.

#### Training

- Copy of the service provider's training, induction and refresher training policy.

- Sight of summary reports on staff induction, training and refresher training records including attendance records.
- Assurance that the MCA features in the job descriptions and personal development reviews of all staff working directly with patients.
- Arrangements for training on restriction and restraint and associated record-keeping. CCGs will pay particular regard to restraint being proportionate to the harm that it seeks to prevent.
- How MCA-related case law's explained to staff and how.
- Evidence that staff are familiar with the Code of Practice and have easy access to it when seeking guidance.

## Supported Decision Making

- Local arrangements around supported decision making – how staff support patients to enhance their ability to make as many decisions for themselves for as long as possible.
- Evidence of how the hospital involves the relevant person and their family and carers in decision-making processes.

## Advocacy

- The service provider's policy on advocacy highlights the role of independent mental capacity advocates (IMCAs), that staff know the circumstances in which a patient should have access to an IMCA and also know how to access the service and where responsibility for so doing lies.
- Data is collected on IMCA referral numbers and trends over time as part of ensuring all patients lawfully entitled to the support of an IMCA in respect of a serious medical treatment decision receive advocacy support.

## Rights and Freedoms

- The rights to liberty and family life are reflected in care planning guidance as part of a process of ensuring patients are involved in, and give informed consent to, care plans. These rights should be reflected in best interests decisions made on behalf of those lacking capacity.

## Governance

- What data and information on compliance with the Act is collected and how are trends and performance reported to Board level and at what frequency? Who is responsible for this and how are recommendations and action plans prepared?
- Evidence of the MCA featuring in audit programmes.
- Evidence of the involvement of clinical governance processes in best interests decision-making through audit and reviews. This would demonstrate how the guidance given in the Code is being applied in practice.
- Board reports on the management and treatment of people lacking capacity.
- Information on how often and in what way the hospital seeks legal advice in relation to the Court of Protection and potential referrals to the Court.
- Evidence that the MCA is linked into the hospital's systems and processes relating to improving service users' experience and the quality of their care and treatment.
- Copies of extracts from CQC reports relating to compliance with the MCA.
- Evidence that legal advisors are familiar with the MCA, up to date with case law and are advising the service provider accordingly.

## Advance Decision Making and Powers of Attorney

- The hospital's policy and procedures in relation to powers of attorney and advance decisions including advance decisions in respect of end of life treatment (it should be noted that a patient may have made an advance decision to refuse treatment [which does not have to be in writing] and an advance decision to refuse end of life treatment [which does have to be in writing]).
- Arrangements for checking and holding copies of advance decisions and powers of attorney and accessing by decision makers.
- Arrangements for determining whether patients have a power of attorney in respect of financial affairs or personal welfare decisions (or both) or a Court Appointed Deputy including contact details of attorneys.
- Guidance on checking the validity of advance decisions and powers of attorney and how to access further assistance in the case of doubt.
- That staff understand the role and responsibilities of a lawfully appointed attorney and how to work with them.
- Guidance on what steps to take if a decision maker reasonably believes an attorney is not acting in the best interests of a vulnerable person.
- Although not binding, how any statements a patient may have made setting out their wishes and feelings about their care and treatment are established and how they are integrated into the best interests decision making process.

Commissioners can seek assurances in relation to the above indicators as part of its routine contract monitoring arrangements with its providers. Alternatively, commissioning leads may wish to establish separate monitoring arrangements. In addition commissioners can seek assurances through the standard contract and the following section deals with this.

In addition CCGs will wish to work with their local authorities to ensure that Best Interests Assessor teams include professionals with a health care background.

## 5. The standard contract and mental capacity

CCGs will be familiar with the standard contract and the template it provides to guide commissioning decisions. Although it does not have a specific section in relation to people who lack capacity, MCA leads in CCGs can request the commissioning board to develop such a section if they wish, as the standard contract is updated annually.

Currently there is limited evidence commissioners are asking questions about the MCA and consideration should be given to including in Quality Schedules or as part of Commissioning for quality and innovation CQINs.

In the meantime, MCA leads can use the following sections and ask hospitals to report on these specifically in relation to people who lack capacity:

- **Service condition 9: policy on consent.** Does this policy address in detail how people who cannot consent will be identified, the role of the decision maker, who is responsible for carrying out assessments of capacity and who is trained and expected to carry out best interests decisions? Is it clear what staff should do if uncertain about a patient's ability to make a specific decision and do they know how to use and apply the best interests decision making checklist?
- **Service condition 1: all services will be compliant with the law.** How does the hospital board assure itself that the hospital is compliant with the MCA? What information does it collect and what does it monitor?
- **Service condition 12: service user involvement.** How does the hospital board assure itself that the experiences and views of those who lack capacity and their families are specifically recorded and acted on?

- **Service condition 13: equality of access and non-discrimination.** How does the hospital board demonstrate that it meets its obligations under the Equality Act 2010? Can it show that people with dementia or learning disabilities (for example) are receiving the same quality of treatment and care as others?
- **General condition 5: hospitals are required to demonstrate they have staff with appropriate experience, skills and competencies.** How does this relate to knowledge of the MCA?

The standard contract is there to support commissioners. Commissioners can ask for information in specific sections in relation to specific groups of people (for example, people with dementia or the elderly); they can use monthly monitoring of service meetings to raise questions and concerns.

The standard contract and the MCA indicators above give CCGs a framework for commissioning compliance with the MCA.

## 6. Winterbourne View and Mid Staffordshire Hospital

Reports into care by the Care Quality Commission and others, including at Winterbourne View and Mid Staffordshire Hospital, have highlighted issues where basic human rights have not been recognised and patients have been neglected and abused as a result.

The MCA is part of a framework aimed at protecting the human rights of vulnerable patients and if applied correctly assures both the provider and the commissioner that this is indeed the case.

Much of what went wrong at Winterbourne View and other places might have been avoided if the service provider had truly understood and acted upon their duty to protect the liberty and security of those in their care as well as understood what the Act says about the duty to

take decisions in the best interests of vulnerable individuals.

## 7. The MCA as part of the quality improvement framework

Applying the MCA as part of the care of patients should not be seen as separate from providing core health services. The Act is integral to the measures a hospital will take to protect and promote the rights of people using its services.

Auditing the use of the Act should be part of an organisation's quality improvement programme. A good compliance approach will cover policy, audit, staff training, personal development, patient information, relative and carer involvement. How the Act is applied locally should form part of a hospital's governance programme.

The MCA is central to quality assurance.

## 8. Brief Guide to the Act

While this document is not meant to be a detailed guide to the Act, CCGs will wish to know the areas it covers so below is a summary of some of its main provisions and in particular those that may be of interest to CCGs:

- **Principles** – establishes five key principles (see section 10).
- **Assessing capacity** – sets down a test for assessing whether a person lacks capacity to take a particular decision at a particular time – the test is decision and time specific.
- **Best interests** – underlines the importance of best interests decision making and provides a non-exhaustive checklist of factors that decision-makers must work through when deciding what is in the best interests of a person assessed as lacking capacity.

- **Acts in connection with care and treatment** – offers a statutory protection from liability where a person is performing an act in connection with the care and treatment of someone who lacks capacity assuming the decision is made within the framework provided by the Act.
- **Restraint** – the Act defines this and provides for the circumstances in which restraint can be used in relation to the care and treatment of somebody lacking capacity (in those circumstances where restriction and restraint may move towards deprivation of liberty the DOLS safeguards must be considered).
- **Future decision making** – the Act allows a person, while they have capacity, to plan ahead for a time when they may lack it through the appointment of a person(s) to take decisions in relation to property and affairs and/or health and welfare on their behalf.
- **Advance decisions** – the Act provides for patients a right to refuse treatment should they lose capacity in the future. It also provides for refusal of end of life treatment but such instructions must be in writing.
- **Court appointed deputies** – the Act allows the Court of Protection to appoint deputies on behalf of people lacking capacity to take decisions on welfare, healthcare and financial matters.
- **Court of Protection** – the Act created this Court which has jurisdiction relating to the whole of the Act.
- **Independent Mental Capacity Advocates(IMCAs)** – patients who lack the capacity to take decisions in relation to serious medical treatment, and have nobody to speak on their behalf, have a legal entitlement to an advocate (IMCA) who will bring to the attention of the decisionmaker information regarding the patient's wishes, feelings, beliefs and values as well as other factors which may be relevant to the decision.

- **Criminal offence** – the Act introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity.
- **Research** – the Act sets out parameters in relation to research involving those who may lack capacity.

Service providers should be familiar with all these provisions and have them embedded into their training, policies, governance and practice. The Act is supported by a **Code of Practice** which provides extensive guidance. Again service providers should be familiar with the Code and must have regard to it.

## 9. Leadership

To be implemented effectively the MCA requires clear leadership at both commissioner and provider level. Organisations should have clear strategies, resources and processes for achieving this.

The benefits for a properly resourced role placed at an influential level within organisations should be clear from this Guide.

The scope and importance of the Act demands clear and focused leadership. It should not be conflated with, or subsumed within, safeguarding or public safety programmes.

## 10. Five Statutory Principles

The MCA is built around five key principles which provide a framework for staff working with patients whether they do, or do not, have capacity to make decisions about their care and treatment:

- **A presumption of capacity:** every adult (aged over 16) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision.
- **Individuals must be supported to make their own decisions:** a person must be given all practicable help before any anyone treats them as not being able to make their own decisions.

- **Unwise decisions:** just because an individual makes a decision others may consider to be unwise, they should not be treated as lacking capacity to make that decision.
- **Best interests:** an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person's best interests.
- **Less restrictive option:** a person doing anything for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms while meeting the identified need.

CCGs will wish to place particular emphasis on being assured these principles are being applied to those in receipt of care on whose behalf treatment is being commissioned. In particular they should seek evidence that compliance with them features in care plans, consent documents, training, audit and patient information etc.

## 11. Deprivation of Liberty Safeguards

The deprivation of liberty safeguards (DoLS) are part of the Mental Capacity Act but were introduced at a later date coming into operation in April 2009.

The safeguards apply to people in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. In the event of it being necessary to deprive a person of their liberty the safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed.

People can be deprived of their liberty in settings other than hospitals and care homes such as supported living but in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations in such circumstances should be made to the Court.

The MCA gives certain responsibilities to staff caring for vulnerable people who lack the capacity to consent to their care and treatment

to use restriction and restraint where it is in the best interests of the person and is necessary to prevent harm. If, however, that restriction and restraint moves towards depriving that person of their liberty it could be unlawful unless authorised by the relevant local authority following an assessment process determined in law.

Article 5 of the European Convention on Human Rights states "everyone has the right to liberty and security of person. No one shall be deprived of his liberty save... in accordance with a procedure prescribed in law."

The challenge for service providers is knowing when its' quite lawful restriction and restraint practices are moving towards depriving the person concerned of their liberty even though it might be in that person's best interests.

Initially the key questions are:

- Is this patients free to leave (whether they are compliant or not) AND
- is this patient subject to continuous supervision and control?

CCGs are reminded that the Safeguards are applicable in health care settings. There will be occasions when it will be necessary in the best interests of an incapacitated patient to deprive that person of their liberty. The Safeguards are not a stigma. On the contrary they protect the rights of the vulnerable person and support the staff looking after them. The independent external assessment process determines this. Care can be excellent but still amount to a deprivation of liberty even though it is the best interests of the vulnerable patient.

As with the wider MCA, CCGs will wish to be assured that the rights of the population on whose behalf it is commissioning services are protected in relation to the safeguards. It will wish to be assured that patients are not being deprived of their liberty unlawfully and that when service users require the protections the safeguards offer they are in place.

The CQC has expressed concerns about the understanding of DoLS by both providers and commissioners. They underline the importance of

robust review processes and improving understanding the experience of those subject to the safeguards. The CQC has also underlined the importance of policies that minimise the use of restraint. A link to the CQC's annual report is given later in this document but the actions suggested below should help CCGs tackle these concerns.

Good practice guidance in relation to DoLS has already been issued to CCGs by the Social Care Institute for Excellence (SCIE) in October 2013 and it is not intended to repeat that guidance here.

The report can be obtained online at [www.scie.org.uk](http://www.scie.org.uk) (free of charge) and the attention of CCGs is drawn to the section of on the role of CCGs pp 19 to 22 inclusive.

The safeguards are supported by a Code of Practice and what has been stated elsewhere in this Guide about the Code for the wider Act equally applies here.

CCGs should be able to seek assurances about DoLS compliance within the framework set out above for the MCA by extending it as appropriate. There should be a focus on the safeguards across all the measures suggested in section 4 above but CCGs may wish to focus on the following:

- There is a clear free standing section covering DoLS in providers' MCA policy or a separate policy but linked to the MCA policy.
- Likewise there is separate staff training on the safeguards.
- Guidance and training on care planning covers the importance of staff being aware of the safeguards in cases where restriction and restraint might be in the patient's best interests.
- Staff know how to access the various DoLS authorisation forms, have had training on their completion and know where they should be submitted.
- DoLS being included in audit and internal review work programmes.

- Evidence that the hospital has established clear and effective working arrangements with its local authority DoLS office.
- Evidence the hospital is aware of responsibility to report DoLS authorisation applications and the outcome to the CQC.
- Evidence the safeguards feature in reports relating to the care and treatment of vulnerable patients particularly those with dementia, a mental illness or learning disability, acquired brain injury, stroke for example.
- Staff have access to the DoLS Code of Practice.
- Local legal advisors are familiar with the safeguards and are briefing the hospital on DoLS related case law.

## 12. Summary

Hospitals and other providers of healthcare services have a duty to know and protect the rights of those receiving care and treatment but especially those that are vulnerable because they lack the ability to take decisions on their own behalf.

Likewise commissioners will wish to be assured that the rights of those on whose behalf they are commissioning services are being protected and delivered in practice.

The MCA provides a statutory framework of rights that empower and protect people who may lack capacity and creates responsibilities for those providing care, the organisations which employ them and those that commission services. By protecting and delivering the rights of vulnerable people abuse, neglect and ill treatment can be avoided and the quality of service delivery improved.

Compliance with the Act is part of the essential framework for providing high quality services. Furthermore it is the law and failure to comply could expose the provider, and potentially the commissioner, to litigation. Organisations would not wish to harm those in their care nor expose

themselves to the risk of loss of reputation and its associated risks.

This guide summarises the rights and duties laid down by the MCA but more importantly flags up a number of performance indicators available to CCGs so that they can monitor compliance, assure themselves the law is being followed and respond accordingly.

**This Guide will be reviewed on  
31st March 2015**

## Useful links

Below are a number of links to further sources of information and guidance on the Mental Capacity Act and the Deprivation of Liberty Safeguards. Some of these links will take you to landing pages which can be explored for other relevant material by using the search or site menu tools.

### **Best interests decision-making**

[www.bestinterests.org.uk](http://www.bestinterests.org.uk)

### **Confidential capacity assessment tool**

[www.amcat.org.uk](http://www.amcat.org.uk)

### **Court of Protection**

<https://www.gov.uk/court-of-protection>

### **Court of Protection case reports**

[www.bailii.org/ew/cases/EWHC/COP/](http://www.bailii.org/ew/cases/EWHC/COP/)

### **Court of Protection newsletters**

<http://www.39essex.co.uk/resources/newsletters.php>

### **Care Quality Commission (CQC)**

<http://www.cqc.org.uk/>

### **CQC DoLS report 2012/13**

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/reports/deprivation-liberty-safeguards-2012/13>

### **CQC – MCA DoLS guidance for providers**

[http://www.cqc.org.uk/search/apachesolr\\_search/Mental%20Capacity%20Act](http://www.cqc.org.uk/search/apachesolr_search/Mental%20Capacity%20Act)

### **CQC – MCA guidance for providers**

[http://www.cqc.org.uk/sites/default/files/media/documents/rp\\_poc1b2b\\_100563\\_20111223\\_v4\\_00\\_guidance\\_for\\_providers\\_mca\\_for\\_external\\_publication.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf)

### **CQC MCA and DoLS pages**

<http://www.cqc.org.uk>

[http://www.cqc.org.uk/search/apachesolr\\_search/Mental%20Capacity%20Act](http://www.cqc.org.uk/search/apachesolr_search/Mental%20Capacity%20Act)

### **Death of a person subject to an MCA DoLS authorisation**

<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

### **Department of Health (DH)**

[www.dh.gov.uk](http://www.dh.gov.uk)

**DH MCA archived pages** (Some of the historical information regarding the MCA and DoLS have been placed in an archive by the Department of Health but the pages remain relevant)

<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

### **European Convention on Human Rights**

<http://www.hri.org/docs/ECHR50.html>

### **European Court of Human Rights**

<http://www.echr.coe.int>

**Health and Social Care Information Centre**

<http://www.hscic.gov.uk/>

**Human Rights Act 1998**

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

**IMCA Service – 5th Annual Report**

<https://www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-fifth-annual-report>

**Lasting Power of Attorney**

<https://www.gov.uk/power-of-attorney/if-you-have-an-enduring-power-of-attorney>

**MCA 2005**

<http://www.legislation.gov.uk/ukpga/2005>

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

**MCA 'Code of practice'**

<http://www.tsoshop.co.uk/>

<http://www.publicguardian.gov.uk/mca/code-practice.htm>

<http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act>

**MCA DoLs "Code of Practice"**

<http://www.tsoshop.co.uk/>

<http://www.publicguardian.gov.uk/mca/code-practice.htm>

<http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act>

**MCA/Deprivation of Liberty Safeguards, Schedule A1, and associated regulations**

[http://webarchive.nationalarchives.gov.uk/20100407222006/http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/DH\\_084948](http://webarchive.nationalarchives.gov.uk/20100407222006/http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/DH_084948)

<http://webarchive.nationalarchives.gov.uk/20100402182610/http://www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm>

**MCA DoLS standard forms** (alternatively forms can be obtained from local authority DoLS offices)

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089772](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089772)

<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm>

**MCA information booklets** ('Making Decisions' series)

<http://www.publicguardian.gov.uk/mca/additional-publicationsa-newsletters.htm>

<http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act>

**MCA 2007 – post-legislative assessment**

<http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act>

**Mental Health Act and Code of Practice**

<http://www.tsoshop.co.uk/>

<http://www.legislation.gov.uk/ukpga/2007/12/contents>

[http://www.lbhf.gov.uk/Images/Code%20of%20practice%201983%20rev%202008%20dh\\_087073%5B1%5D\\_tcm21-145032.pdf](http://www.lbhf.gov.uk/Images/Code%20of%20practice%201983%20rev%202008%20dh_087073%5B1%5D_tcm21-145032.pdf)

**Mental Health Foundation MCA literature review**

<http://www.mentalhealth.org.uk/publications/mca-lit-review/>

**Mental Health Law Online**

[www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)

**Ministry of Justice**

<http://www.justice.gov.uk>

**National Institute for Health and Clinical Excellence (NICE) quality standard and guidance for patient experience in adult NHS services**

<http://www.nice.org.uk/guidance/qualitystandards/patientexperience/home.jsp>

<http://www.nice.org.uk/newsroom/pressreleases/PatientExperienceQSAndGuidance.jsp>

**National Institute for Health and Clinical Excellence (NICE) quality standard for service user experience in adult mental health**

<http://www.nice.org.uk/guidance/qualitystandards/service-user-experience-in-adult-mental-health/index.jsp>

**NHS Commissioning Board: 'Commissioning for quality and innovation' guidance**

<http://wwwcommissioningboard.nhs.uk/files/2013/02/cquin-guidance.pdf>

**Office of the Public Guardian (OPG)**

[www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)

**Patient Experience Framework**

This has been agreed by the National Quality Board and describes the aspects of a health care experience which service users have said matter most to them. Clearly different people in different settings will have different priorities for what is important within this framework.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132786](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132786)

**Post Legislative Assessment – Mental Health Act 2007** (also covers the amendments to Mental Capacity Act to include DoLS)

<http://www.official-documents.gov.uk/document/cm84/8408/8408.pdf>

**Social Care Institute for Excellence – MCA and DoLS resources**

[www.scie.org.uk](http://www.scie.org.uk)

**'Transforming Patient Experience'**

A guide published in February 2013 by the NHS Institute

[http://www.institute.nhs.uk/patient\\_experience/guide/home\\_page.html](http://www.institute.nhs.uk/patient_experience/guide/home_page.html)

**Universal Declaration of Human Rights (UDHR)**

[www.un.org/en/documents/udhr/](http://www.un.org/en/documents/udhr/)

**Social Care Institute for Excellence: DoLS Good Practice Guide**

<http://www.scie.org.uk/publications/reports/report66.asp>

# Glossary

## Acts covered by the MCA

Tasks carried out by carers, healthcare or social care staff which involve the personal care, healthcare or medical treatment of people who lack capacity to consent to them.

## Advance Decision to Refuse Treatment

A decision to refuse specified treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when the person lacks the capacity to consent to, or refuse, the specified treatment (Specific rules apply to advance decisions to refuse life-sustaining treatment).

## Adult Protection Procedures

Procedures devised by local authorities, with partner organisations, to investigate and deal with allegations of abuse or ill treatment of vulnerable people and to put in place appropriate safeguards.

## Attorney

Someone appointed under either a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA), who has the legal right to make decisions within the scope of their authority on behalf of the person (known as the donor) who made the power of attorney.

The holder of a LPA can make decisions about the donor's personal welfare (including healthcare) and/or the donor's property and affairs.

## Best interests

Any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests.

## Capacity

The ability to make a decision about a particular matter at the time the decision needs to be made.

## Court of Protection

The specialist Court for all issues relating to people who lack capacity to make a specific decision.

## Decision-maker

The person responsible for taking a specific decision on behalf of someone who lacks the capacity to make that decision for themselves. This person is identified by the nature of the task. It is the decision-makers responsibility to work out what would be in the best interests of the person lacking capacity.

## Deputy

Someone appointed by the Court of Protection with ongoing legal authority as prescribed by the Court to make decisions on behalf of a person who lacks capacity to make particular decisions.

## Ill-treatment or neglect

New offences introduced by the Act in relation to people lacking capacity.

## Independent Mental Capacity Advocate (IMCA)

A specially trained advocate who provides support and representation to person who lacks capacity to make a specific decision and has no-one else to speak on their behalf and is facing a serious medical treatment or long term accommodation decision.

## Office of the Public Guardian

Provides a range of services in relation to deputies and attorneys including supervision, registration and investigation of complaints.

## Official Solicitor

Provides legal services for vulnerable adults including representing those who lack capacity to conduct litigation in Court.

## Restraint

The use or threat of force to help do an act which a person who lacks capacity resists. The act must be in the best interests of the person and to protect them from harm. It must be proportionate to that risk of harm.

## Statutory principles

The five key principles set out at the beginning of the Act which set down the fundamental concepts and core values of the Act and provide a benchmark to guide decision-makers and all those involved in the care and treatment of people who may lack capacity.

## Two-stage Test of Capacity

The procedures set down in the Act to determine whether a person has the capacity to take a specific decision at the time they need to take it.

## Wishes and feelings

Statements a person might have made before losing capacity about their wishes and feelings regarding their future treatment and care. Although not binding they should be used to shape best interest decisions.

## Case Law

This appendix provides a sample of MCA related cases that have been before the Court of Protection the outcomes of which will be of interest to CCGs. It is not meant to be a comprehensive guide to the case law and CCGs should have their own arrangements for keeping up to date with case law developments.

Although some of these cases feature local authorities it does not follow the rulings do not apply to CCGs when making similar decisions. Further information on the case listed and others can be found via the following links:

[www.bailii.org/ew/cases/EWHC/COP/](http://www.bailii.org/ew/cases/EWHC/COP/)

[www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)

### **Westminster City Council v Manuela Sykes [2014] EWHC (COP)**

The importance of the right to family life and living at home when making best interest decisions in respect of the long term care and treatment of vulnerable people who express unhappiness at living in a care home or similar institution.

### **Newcastle Upon Tyne Hospitals Foundation Trust v LM [2014] EWHC454 (COP)**

A recent case involving advance decisions to refuse treatment including end of life treatment.

### **AH v Hertfordshire Partnership NHS Foundation Trust & Anor [2011] EWHC276 (COP)**

Policy guidelines, while important, should not be considered a universal solution and applied in a way which pushes aside the best interests of vulnerable people. Best interests should be determined by a proper and objective assessment on every occasion.

### **A London Local Authority v JH & Anor [2011] EWHC2420 (COP)**

This case relates to discharge from hospital after serious illness and provides a useful framework for making complex and difficult decisions in the choice between home care and nursing home care.

### **KK v STCC [2012] EWHC2136 (COP)**

This case underlines the importance of not pushing aside the presumption of capacity because a vulnerable person may not understand the complexity or peripheral detail of a decision. As long as they generally understand the decision expected of them that should suffice. Neither should the outcome of a best interests assessment be prejudged because of concerns about risks and safety. The case also focuses on the right to family life – on this occasion the bungalow that KK wished to return to.

### **R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014]**

EWCA Civ 33 (Court of Appeal)

Decisions on whether to resuscitate patients will, in the not-to-distant future, be the subject of a substantive ruling from the Court of Appeal.

### **A NHS Hospital Trust v M and K [2013] EWHC 2402(COP)**

A recent case relating to withholding life sustaining treatment in the most challenging cases which links to a number of judgements on the subject.

### **Aintree University Hospitals NHS Foundation Trust v James & Ors [2013] EWCA Civ 65**

A significant ruling re the provision and withholding of serious medical treatment which considers quality of life issues while taking account of the wishes of the person involved.

### **Supreme Court judgement – P v Cheshire West and Chester Council and P & Q v Surrey County Council**

Recent case law cases relating to the Deprivation of Liberty Safeguard

[http://supremecourt.uk/decided-cases/docs/UKSC\\_2012\\_0068\\_Judgment.pdf](http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf)

# Appendix: Commissioners checklist

## Policy

- ✓ Copies of service providers' MCA policies
- ✓ Evidence that each hospital etc has an MCA lead.
- ✓ Written evidence of MCA-compliant capacity assessments and best interests decision-making documentation and procedures.
- ✓ Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning policies, guidance and training.
- ✓ Evidence that the MCA is linked into the hospital's systems and processes relating to improving service users' experience and the quality of their care and treatment.
- ✓ Policies on research recognise the rights of those lacking capacity.

## Training

- ✓ Copy of the service provider's training, induction and refresher training policy.
- ✓ Sight of summary reports on staff induction, training and refresher training records including attendance records.
- ✓ Assurance that the MCA features in the job descriptions and personal development reviews of all staff working directly with patients.
- ✓ Arrangements for training on restriction and restraint and associated record-keeping. CCGs will pay particular regard to restraint being proportionate to the harm that it seeks to prevent.
- ✓ How MCA-related case law explained to staff and how.
- ✓ Evidence that staff are familiar with the Code of Practice and have easy access to it when seeking guidance.

## Supported Decision Making

- ✓ Local arrangements around supported decision making – how staff support patients to enhance their ability to make as many decisions for themselves for as long as possible.
- ✓ Evidence of how the hospital involves the relevant person and their family and carers in decision-making processes.

## Advocacy

- ✓ The service provider's policy on advocacy highlights the role of independent mental capacity advocates (IMCAs), that staff know the circumstances in which a patient should have access to an IMCA and also know how to access the service and where responsibility for so doing lies.
- ✓ Data is collected on IMCA referral numbers and trends over time as part of ensuring all patients lawfully entitled to the support of an IMCA in respect of a serious medical treatment decision receive advocacy support.

## Rights and Freedoms

- ✓ The rights to liberty and family life are reflected in care planning guidance as part of a process of ensuring patients are involved in, and give informed consent to, care plans. These rights should be reflected in best interests decisions made on behalf of those lacking capacity.

## Governance

- ✓ What data and information on compliance with the Act is collected and how are trends and performance reported to Board level and at what frequency? Who is responsible for this and how are recommendations and action plans prepared?
- ✓ Evidence of the MCA featuring in audit programmes.

- ✓ Evidence of the involvement of clinical governance processes in best interests decision-making through audit and reviews. This would demonstrate how the guidance given in the Code is being applied in practice.
- ✓ Board reports on the management and treatment of people lacking capacity.
- ✓ Information on how often and in what way the hospital seeks legal advice in relation to the Court of Protection and potential referrals to the Court.
- ✓ Evidence that the MCA is linked into the hospital's systems and processes relating to improving service users' experience and the quality of their care and treatment.
- ✓ Copies of extracts from CQC reports relating to compliance with the MCA.
- ✓ Evidence that legal advisors are familiar with the MCA, up to date with case law and are advising the service provider accordingly.
- ✓ Guidance on checking the validity of advance decisions and powers of attorney and how to access further assistance in the case of doubt.
- ✓ That staff understand the role and responsibilities of a lawfully appointed attorney and how to work with them.
- ✓ Guidance on what steps to take if a decision maker reasonably believes an attorney is not acting in the best interests of a vulnerable person.
- ✓ Although not binding, how any statements a patient may have made setting out their wishes and feelings about their care and treatment are established and how they are integrated into the best interests decision making process.

Commissioners can seek assurances in relation to the above indicators as part of its routine contract monitoring arrangements with its providers. Alternatively, commissioning leads may wish to establish separate monitoring arrangements. In addition commissioners can seek assurances through the standard contract and the following section deals with this.

In addition CCGs will wish to work with their local authorities to ensure that Best Interests Assessor teams include professionals with a health care background.

## Advance Decision Making and Powers of Attorney

- ✓ The hospital's policy and procedures in relation to powers of attorney and advance decisions including advance decisions in respect of end of life treatment (it should be noted that a patient may have made an advance decision to refuse treatment [which does not have to be in writing] and an advance decision to refuse end of life treatment [which does have to be in writing]).
- ✓ Arrangements for checking and holding copies of advance decisions and powers of attorney and accessing by decision makers.
- ✓ Arrangements for determining whether patients have a power of attorney in respect of financial affairs or personal welfare decisions (or both) or a Court Appointed Deputy including contact details of attorneys.





