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Mental Capacity Act 2005

Practice Guidance for Staff Working in Health and Social Care

Redraft: Version 4.0

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Contents		Page
1	What is the Mental Capacity Act?	3
2	Purpose of this guidance	3
3	Code of Practice	3
4	Exclusions from the Mental Capacity Act	4
5	The Principles of the Mental Capacity Act	4
5	Definition of Capacity	4
6	What does the Mental Capacity Act do?	5
7	Professional Protection	5
8	Who Can Assess Capacity?	6
9	Informal Decisions	6
10	Formal Assessments	7
11	Assessments of Capacity (SOC1708/ CPA 8 part 1)	10
12	Capacity Assessment Stage 1: Diagnostic threshold	11
13	Capacity Assessment Stage 2: Functional test	12
14	Supporting the decision & maximising capacity	12
15	Does the person have capacity to make the decision?	12
16	Best Interests Consultations (SOC1708/ CPA 8 part 3.1)	14
17	Best Interests Considerations (SOC1708/ CPA 8 part 3.2)	15
18	Best Interests Decisions (SOC1708/ CPA 8 part 3.3)	16
19	Counter-signing Assessments	17
20	Involvement of Carers	17
21	Self funding clients	18
22	Independent Mental Capacity Advocates	18
23	Lasting Powers of Attorney	21
24	Enduring Powers of Attorney	25
25	Roles of Court Appointed Deputy & Court of Protection	25
26	Advance Decisions to Refuse Treatment	26
27	Finance	28
28	Restraint	29
29	Transport and Conveyance	29
30	Research Involving People who Lack Capacity	30
31	The Mental Capacity Act and Children and Young People	30
32	The Mental Capacity Act and the Mental Health Act 1983	31
33	Deprivation of Liberty Safeguards	33
34	Mental Capacity Act and Protection of Vulnerable Adults	37
35	Confidentiality, Disclosure and Consultation	39
36	Glossary of terms	40

1 What is the Mental Capacity Act?

The Mental Capacity Act (MCA) specifies the legal framework under which a decision can be made for someone over 16 in England and Wales who lacks the capacity to make it him or herself.

Under the MCA, someone making a specific decision for him or herself has the right to all practical support to help them make the decision. Health and social care staff are committed under the MCA to finding ways to maximise a person's ability to make a decision.

If, after providing all practical support, it seems likely that the person does not have the capacity to make the decision, then the person's right to have his or her best interests met must be respected. The MCA sets out how a 'best interests' decision can be made.

The Mental Capacity Act and easy read leaflets and summaries can found through the Cambridgeshire County Council Mental Capacity Act Website:
<http://www.cambridgeshire.gov.uk/social/mental>

2 Purpose of this procedure

The purpose of this procedure is to inform health and social care staff in Cambridgeshire about the local arrangements for working with patients/users of services over the age of 16 with impaired mental capacity.

This document sets out the procedures for all staff to follow in the event of concerns to assess capacity. Its purpose is to state the agreed Policy for the Assessing the capacity of service users in Cambridgeshire. It provides guidance on the use of the Capacity Assessment and Best Interests form SOC 1708 / CPA part 8.

The policy decision in Cambridgeshire, in line with the spirit of the Mental Capacity Act, is not to restrict capacity assessments to specified groups of professionals or to particular grades or bands. Under the Mental Capacity Act, depending on the decision, any health or social care worker may assess capacity. However, there is a level of formal decision that will require the completion of the Assessment form SOC1708. Those staff who have responsibility for these types of decisions as part of their role will need to be more familiar with SOC1708.

All health and social care staff must be familiar with the MCA Code of Practice and have regard to it in their work.

3 The MCA Code of Practice.

The Code of Practice focuses on those who have a duty of care to someone who lacks the capacity to agree to the care or treatment that is being provided. It describes the responsibilities when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves.

It explains that those who lack capacity have the right to have their care and treatment options explored in order to come to a decision in their best interests.

The Code of Practice has statutory force. Staff have a formal duty of regard to the Code of Practice when working with or caring for adults who may lack capacity to make decisions for themselves.

The Code of Practice is available from
<http://www.justice.gov.uk/guidance/mental-capacity.htm>

4 Exclusions from the Mental Capacity Act.

Sections 27-29 and 62 of the Mental Capacity Act set out the specific decisions or actions that cannot be made or taken under the Act. The Mental Capacity Act cannot be used to make a decision on behalf of someone on any of the following matters:

- Consenting to marriage or civil partnership
- Consenting to have sexual relations
- Consenting to the dissolution of a civil partnerships
- Consenting to a decree of divorce after 2 years' separation
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property
- Giving consent under the Human fertilization and Embryology Act 1990
- Voting at an election for public office or at a referendum on behalf of someone who lacks capacity.

5 The principles of the Mental Capacity Act

The Mental Capacity Act commences (Mental Capacity Act Section 1(1-5)) with a statement of principles that govern all the circumstances in which the MCA is applied.

The principles make it clear that the emphasis in the Mental Capacity Act is on ability and capacity, and on ensuring that all decisions made on behalf of a person who lacks capacity are made in the person's best interests.

The principles confirm that all practical efforts must be taken to respect the person's right to make decision on their own behalf.

The principles are:

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

6 Definition of Capacity.

Someone can only be considered as lacking capacity if they are unable to make a particular decision at the time when the decision needs to be taken. The Mental Capacity Act brings in a statutory definition of a person who lacks capacity:

“For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he or she is unable to make a decision for him/ herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’ (Mental Capacity Act 2005 Section 2(1))

In all circumstances, capacity must be regarded within the context of the ‘material time’: capacity should be assessed on the basis of THIS decision to be made by THIS person at THIS moment in time.

Any question whether a person lacks capacity under the meaning of the MCA must be settled on the balance of probabilities; that is, on what can be regarded as being more likely than not to be the case.

6 What does the Mental Capacity Act do?

- It creates a statutory framework for assessing capacity
- It establishes a non-exhaustive checklist to help determine what is in the best interests of a person lacking capacity.
- It introduces statutory responsibilities for everyone who works with people over 16 who lack capacity to make a particular decision.
- It provides several ways that people can influence what happens to them if they are unable to make particular decisions in the future. These are specifically Advance Decision to Refuse Medical Treatment, statements of wishes and feelings and creating Lasting Powers of Attorney (existing Enduring Powers of Attorney will continue to be valid).
- It offers protection from liability to those professionals who make decisions on behalf of someone who lacks capacity, providing that the assessment and decision are according to the MCA and the code of practice.
- It establishes an obligation to consult people who are interested in caring for the person who lacks capacity and anyone interested in their welfare.
- It creates a new advocacy service called the Independent Mental Capacity Advocate Service (IMCA)
- It establishes the new criminal offence of Ill-Treatment or Neglect.
- It establishes new safeguards for undertaking research involving people who lack capacity
- A sets up a new Court of Protection and a new public official post (the Public Guardian) who is supported by the Office of the Public Guardian.

7 Professional Protection.

The Mental Capacity Act is protective legislation. Its primary purpose is to protect people who may lack capacity.

It also offers protection to those who may need to make decisions on behalf of people who lack capacity. Section 5 of the Mental Capacity Act provides them with ‘protection from liability’. It protects them from being prosecuted for acts that could otherwise be regarded as civil wrongs or even crimes.

A carer who helps bathe someone who lacks capacity to agree is doing so without the person's consent and so theoretically could be committing assault. The MCA realises that such assistance with care could be in someone's best interests and that the carers should be protected from any risk of prosecution if they are acting in the best interests of the person who lacks capacity.

As long as staff can demonstrate that they have followed the principles of the MCA and the Code of Practice, they will be protected from liability. The protection covers the process through which the decision is taken on behalf of someone, rather than the decision itself. In this way, if the decision has unforeseen, damaging consequences, staff will still be protected from liability as long as they can establish that at the time the decision was taken, they believed that it was in the person's best interests.

This means that protection from liability will arise if staff can show that there is a reasonable belief that the person lacks capacity to make the decision as defined in the MCA and that the action on the person's behalf follows the MCA best interests checklist.

8 Who can assess capacity?

Under the Mental Capacity Act, capacity assessments are the **responsibility of the person who has responsibility for the decision**. Throughout this Guidance (and the Mental Capacity Act Code of Practice) the person with responsibility for the decision is referred to as the **Decision Maker**.

The decision maker is the person who would normally be the person who would make the decision on behalf of a person who lacked the capacity to make the decision.

In informal situations, the decision maker may be informal carers or family members who make decisions on behalf of a cared for person. However, the legal authority of informal carers, family and next of kin to make more serious decisions such as to consent to or refuse treatment or social care is limited only to those who hold a relevant power of attorney or deputyship. In all other circumstances such decisions are ultimately the responsibility of the relevant professional.

The decision maker is the person with the responsibility for the decision. The decision maker would normally be the professional who would discuss the decision with the person and support the person to make the decision.

It may be that within a multidisciplinary team discussion it is agreed that the role of decision maker is to be shared between professionals. This arrangement would need to be supported by the rest of the multidisciplinary team and the respective line management.

The Decision Maker may involve others in the assessment when necessary, though the Decision Maker has the responsibility to arrive at a best interests decision on behalf of someone who lacks the capacity to make it.

In the course of their work, all levels of health and social care staff will need to assess a person's capacity to make a particular decision and different levels of decision will require different levels of assessment.

9 Informal Decisions

Day to day decisions, such as bathing, feeding and personal care can be covered within the care plan. The care plan should record the manner in which the person's capacity has been assessed and specify how the care need can be met in the person's best interests in the least restrictive manner. The care plan should cover the decisions that the person lacks the capacity to make and the best interests way to meet the person needs.

Care plan decisions would not necessarily require the completion of SOC 1708 and can be recorded in the relevant record. The care plan should include prompts to explain the decision or action to the person each time it is required and ways to involve the person. A reference should be made in the relevant record each time this element of the care plan is implemented.

Care assistants need to have care plan guidance especially when a person resists or refuses a care act or medication. In the first instance the care assistant should not be expected to force a care act or medication on someone, and should refer the situation back to the senior staff or the care co-ordinator.

If restraint is to be considered in any circumstances, the nature of the restraint and its application should be specified in the care plan, along with the reasoning regarding why the restraint is in the person's best interests and is the least restrictive way to protect the person from an identified harm. The care plan should also include the attempts made to explain the situation to the person and how the restraint is to be reviewed (see section on restraint on page 33 below).

An applicable LPA, deputy arrangement or advance decision would carry the legal authority for the decision.

10 Formal Assessments

Decisions that have consequences beyond the day-to-day may require formal assessments using the assessment form SOC1708/CPA part 8. Cambridgeshire County Council does not restrict the completion of formal assessments to staff on particularly grades or in particular roles as such: whether or not a formal assessment will in required will depend on the nature of the decision.

However, in practice, formal assessments will only be required for decisions that have significant consequences. Therefore, only those staff that hold the responsibility for such decisions within their job role will be required to assess capacity.

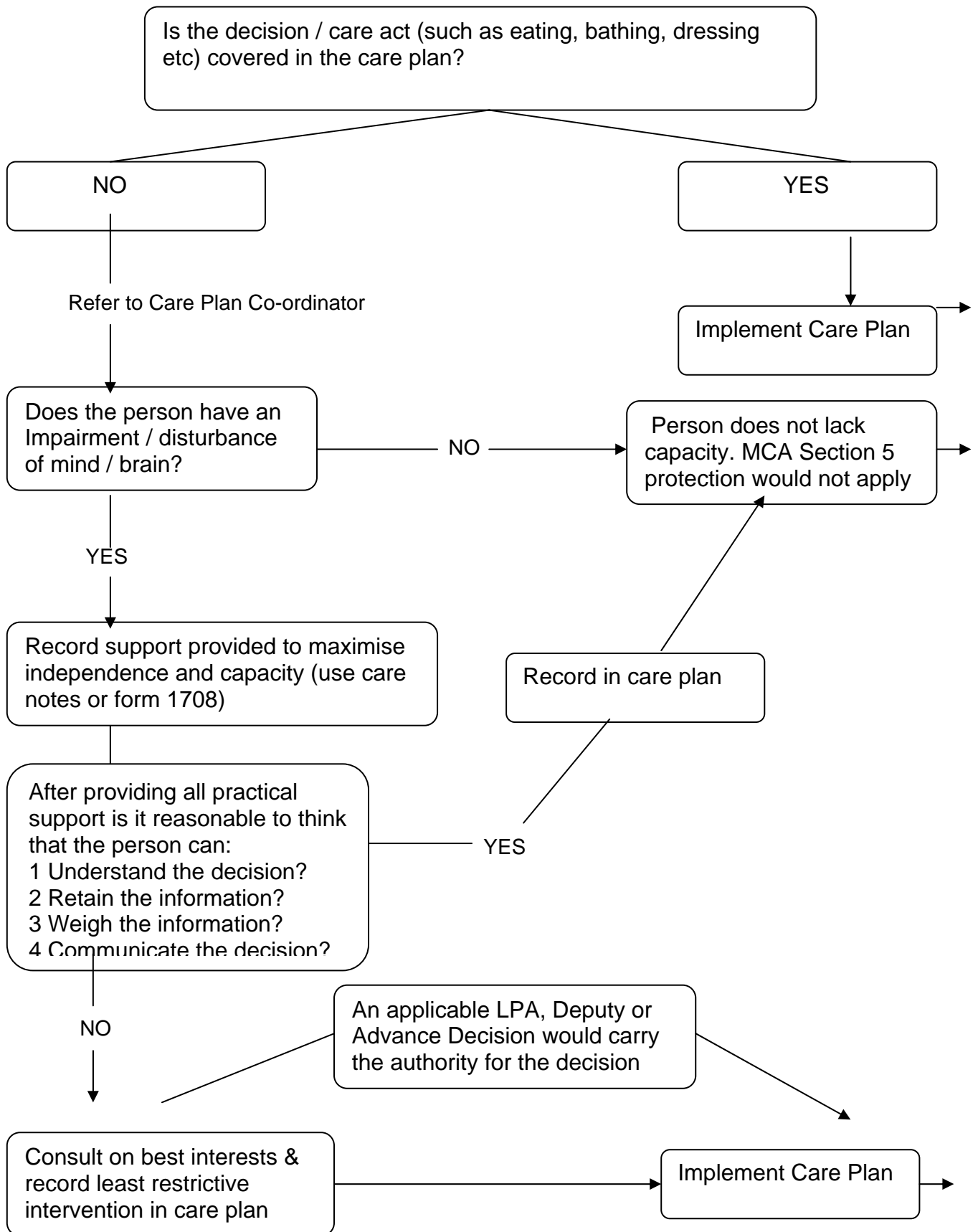
The MCA itself makes no formal distinction on which decisions require formal assessments. Questions to guide when formal assessments should be undertaken include:

- Does the decision have long term / significant consequences?
- What is the likelihood that the decision may be challenged?
- Does the decision relate to a situation of substantial or critical risk?
- Is there likely to be disagreement or challenge in the decision?

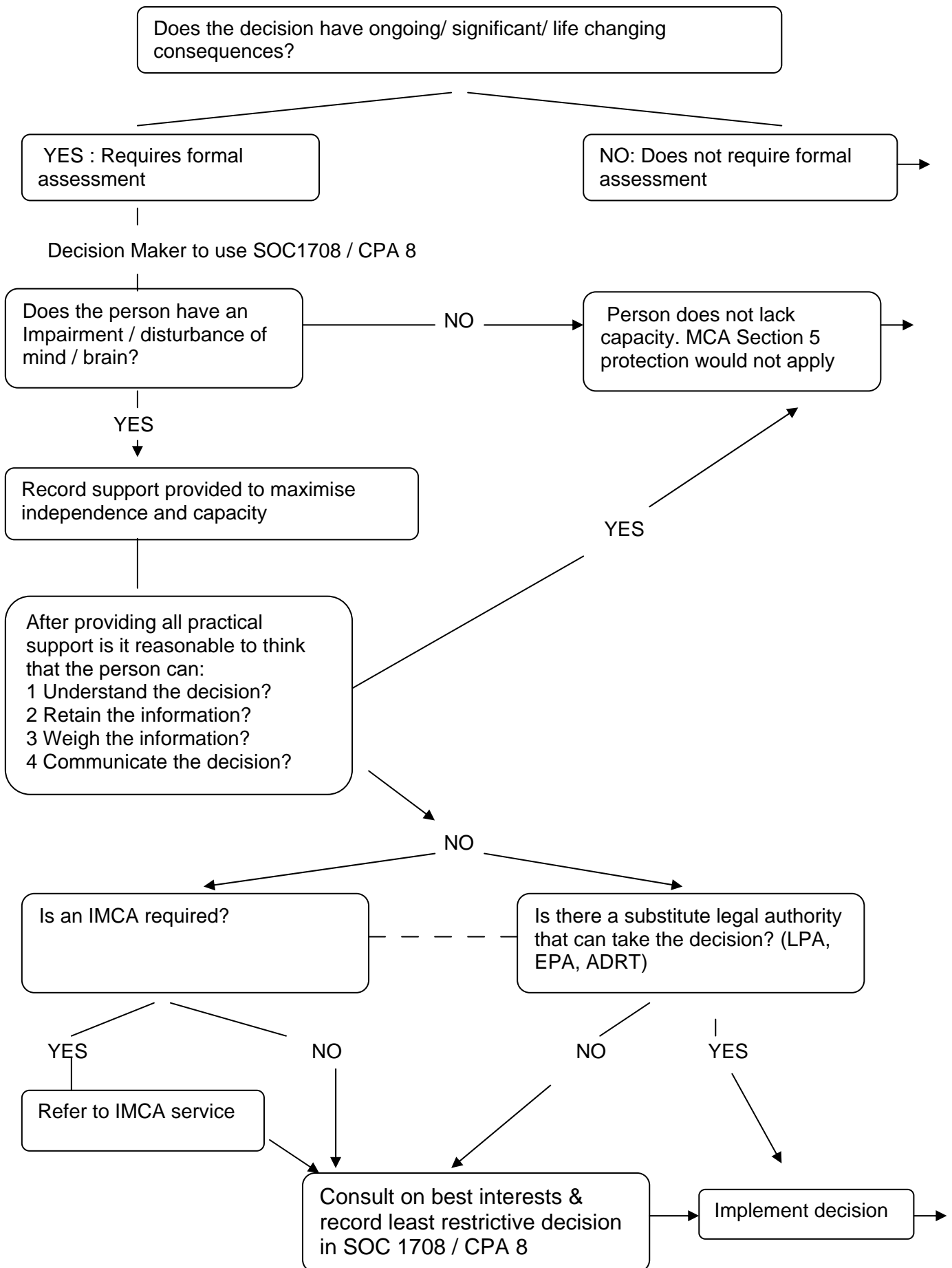
When a person is compliant with a decision, though without the capacity to make it, the capacity assessment and best interests reasoning do still need to be documented, not least because the person may have a right to an Independent Mental Capacity Advocate.

Decisions which require formal assessments should be recorded using SOC 1708 / CPA part 8 Capacity Assessment form.

Flow chart for Informal Capacity Assessments



Flow Chart for Formal Capacity Assessments



Decisions requiring formal assessment (SOC 1708) would include:

- Accommodation change (including move to different support within facilities such as transfer to nursing care within the same care home)
- Alteration in day care arrangements • Management of client finances
- Serious medical treatment • Consent to informal admission (hospital, nursing, care home)
- Request a Tribunal Hearing when detained under MHA (1983)
- Care package arrangements • Deprivation of liberty.
- Serious concerns over a person's ability to manage risk.

**Decisions which may not require formal assessments would include:
(to be decided case by case on seriousness or complexity of the decision, otherwise document in relevant record)**

- Disclosure of information • Referrals to other agencies • Movement from like to like accommodation within the same facility (such as ward to ward, room to room, ward to interim arrangement still under hospital care etc)

Decisions which do not require capacity assessments:

- Situations in which the MCA cannot be applied (see Code of Practice 1.8 -1.11)
- Decision taken under Mental Health Act 1983 (though see section below)
- Decisions regarding children under 16 should be made under relevant children's legislation or under the jurisdiction of the Court of Protection.
- Situations that do not require input, consent or agreement from the person (for example, a person may be considered medically fit for discharge: this would be clinical decision and would not be dependent on the person's consent or agreement). However, subsequent decisions (such as where the person moves to) may be decisions ordinarily requiring input and agreement and therefore would need formal capacity assessments.
- Where there are no reasonable doubts against the person's capacity to make the decision

Formal capacity assessments are not required in each and every case. Formal assessments are not required when there are no reasonable doubts against capacity. The support and information provided to the person should still be documented in the relevant record. There is no need to follow the best interests considerations when a person has capacity to make the decision.

The SOC 1708 form is to be completed by the decision maker. The decision maker would be the health and social care worker with the responsibility for the decision.

The 'role' of decision maker may be fulfilled by more than one person. In these cases, each person should sign the assessment form, each person should take a copy of the form for the respective line manager to 'sign off'.

11 Assessments of Capacity

All capacity and best interests assessments are required to be settled on the balance of probabilities (Mental Capacity Act Section 2005 2(4)).

In terms of the Mental Capacity Act, capacity relates to a specific decision at the specific time that is required and not to a general ability to make decisions.

'Blanket' statements that indicate that a person lacks capacity to make all decisions (unless the person is unconscious), or statements that assume that someone lacks capacity on the basis of a diagnosis, or condition or age or other factor are all unlawful under the Mental Capacity Act.

When assessing the capacity to make a particular decision staff must have regard to the MCA Code of Practice (especially chapter 4).

Mental Capacity Act 2005 Section 2

Mental Capacity Act 2005 Code of Practice Chapter 4

The statutory Capacity Assessment framework, which has been incorporated into the SOC 1708 / CPA pt8 form, sets out a 2 stage assessment:

- As laid out in the MCA Section (2) 1 Stage 1 of the assessment determines whether or not the person has **“an impairment of, disturbance in the functioning of, the mind or brain”**.
- Stage 2: of the assessment determines whether the impairment or disturbance leads to an inability to make the decision. The Mental Capacity Act 3(1) clarifies how this is to be established (See below)

Stage 1 is referred to as the 'diagnostic threshold' and stage 2 is referred to as the 'functional test'.

12 Capacity Assessment Stage 1: Diagnostic threshold.

While there is no requirement in the MCA for a formal diagnosis, the issue of whether or not an impairment or disturbance exists must be reasonably settled on the balance of probability. The impairment or disturbance may be temporary or permanent: it is a matter of whether or not it is the case at the material time when the decision is to be made.

Evidence could refer to:

- Existing & current diagnosis (including dementia, mental health condition; learning disability)
- Head injuries
- Substance use
- Unconsciousness
- Physical conditions that cause confusion.
- Memory impairment
- Cognitive Impairment

There is no suggestion that a non-medically or mental health trained staff member is required to make a formal diagnosis of any condition. Again, a formal diagnosis is not required by the MCA, though clearly if one exists and is current, then stage 1 becomes more straightforward. Any relevant evidence, such as incident reports, care and case notes, the opinion of other professionals could well be sufficient. The assessor is required to record reasonable evidence that the person does have an impairment or disturbance.

If there is no reasonable evidence for an impairment or disturbance of the functioning of the mind or brain, the person cannot be deemed to lack capacity under the Mental

Capacity Act. The Capacity Assessment is ended and the Mental Capacity Act cannot be further applied.

If there is evidence of an impairment or disturbance under stage 1, then the capacity assessment can progress to stage 2. The impairment or disturbance in itself must not be taken to indicate a lack of capacity.

Mental Capacity Act 2005 Section 2

Mental Capacity Act 2005 Code of Practice 4.11 & 4.12

13 Capacity Assessment Stage 2: Functional Test.

The Mental Capacity Act 2005 Section 3 defines four elements of a decision. A person needs to:

- Understand the information relevant to the decision
- Retain the information for long enough for the decision to be taken
- Weigh the information relevant to the decision
- Communicate the decision

In order to be assessed as having capacity, the capacity assessment needs to demonstrate that the person can achieve all four elements of stage 2.

It follows from this that if the capacity assessment demonstrates an over-riding difficulty with a single element then the person can reasonably be said to lack capacity

The four components are closely linked and there is no requirement for each one to be assessed separately. An assessment of capacity can look at the whole process. The same piece of evidence or assessment may support different elements of the process and, for example, a person's inability to retain information may also demonstrate a significant difficulty to understand it.

14 Supporting the decision and maximising capacity.

The assessment of capacity is governed by the principles of the Mental Capacity Act and the decision maker is required to try all practical ways to support the person and maximise the person's capacity to make the decision. In essence, the question the MCA asks is "what have you done to support the person in the decision?"

The support provided to the person needs to be recorded on form SOC 1708.

15 Does the person have the capacity to make the decision?

'YES' to ALL of the elements of Stage 2

If the person is able to complete **all four** elements of a decision then the person has capacity to make the decision as defined by the Mental Capacity Act. The Act cannot be applied and the assessment process is ended. A person with capacity can withhold consent for any or no reason. They can also take an 'unwise' decision. This must be respected though not necessarily supported.

Suggestions to maximise capacity.

General Points:

- Choose place where the person feels at ease
- Choose quiet location, respect privacy and dignity
- Choose time when the person is most alert
- Consider side effects of medication
- Challenge unnecessary time limits & deadlines
- Involve speech & language therapists
- Non-verbal communication may take more time.
- Involve family, friends, carers etc.
- Identify preferred communication means

Understanding the information relevant to the decision:

- Simply language and provide information in small chunks
- Use visual aids and prompts
- Use translation & interpreters
- Consider cultural & linguistic needs

Retaining the information relevant to the decision:

- Threshold is decision specific: information to be retained for as long as is needed to make a decision
- Use a variety of materials: written, photographs, pictures.
- Ask the person to repeat the information in his / her own words.
- Tape the information so that the person can play it back
- Break routines into small steps
- Hold follow up meetings

Weighing the information relevant to the decision:

- Present / prompt options to the person
- Use supported decision making tools to prompt and focus conversation
- Explore reasons behind the choice (for example someone may not choose to attend hospital appointment because of anxiety over travelling)
- See if person can identify pros and cons

Communicating the decision:

- Use translation & interpretation
- Consult with carers, family, friends over how best to communicate.
- Reducing anxiety: using comfortable, familiar surroundings or involving someone the person is comfortable talking to.
- Use 'non-verbal' communication.

Suggested Assessment Template: Accommodation decisions

- Gauge and identify preferred way of communication
- Relate the decision to the 'here & now' of the person: what is the person's current experience of present accommodation: what is liked? What is disliked?
- What has been their experience of changing accommodation in the past?
- Arrange visits to potential accommodation & hold 'debriefing' to see what the person liked or disliked (retaining & weighing information)
- Use brochures & photographs of accommodation to prompt discussion
- Present the concerns of other people
- Recognise levels of distress & anxiety
- Involve family, friends and carers
- Explore insight into potential risks.

If a person has capacity SOC1708 would finish at this point. Sections 2 and 3 should not be completed.

No to ANY of the elements of Stage 2

If, after establishing stage 1, a person is regarded as unable to achieve **any one** of the four parts of the functional test, then they can be reasonably said to lack capacity. Almost by definition “reasonable belief” is not intended to be exact or absolute.

There are some ‘rules of thumb’ to help arrive at a reasonable belief:

- One would be to consider if another professional could reasonably be expected to reach the same conclusion.
- What can be considered reasonable will also be determined by the amount of time available for the decision.

There are a number of consequences as a result of a person being assessed to lack capacity

- If applicable Powers of Attorney are in place then the capacity assessment could be the trigger for the powers of attorney to be active.
- An application could be made to the Court of Protection to appoint a Deputy in the area in which the person is lacking capacity.
- If the criteria are met, the assessment of incapacity would trigger a referral to the IMCA service.
- The decision would need to be taken in the Best Interests of the individual

Mental Capacity Act 2005 Section 3

Mental Capacity Act 2005 Code of Practice 4.13 – 4.32

After completing Section 1 of the SOC 1708 form, the decision maker should complete section 2 regarding whether or not a referral is to be made to the IMCA service. Guidance for this can be found in section 4 below.

16 Best Interests Consultations (SOC 1708 / CPA 8 part 3.1)

If a person has capacity there is no requirement to complete section 3.

The Supplementary Sheet SOC 1708a ‘Relevant Party Best Interests Consultation Record Sheet’ is to be used to document consultations. This sheet can be used to prompt and record the consultation with the relevant party (family member, friend, other professional etc). The relevant party can be asked to sign the sheet as a record of the consultation, and can also be given a copy of the sheet. There is no requirement to share the full capacity assessment with the relevant party.

The list of all consultations and a summary of the findings should be recorded in part 3.1 of the assessment form. This provides a space to record the results of all consultations

The Decision maker is obliged (under Mental Capacity Act 2005 4(7)) to consult with anyone who may have a relevant interest in the decision or who may offer valuable insight and information as to the person’s wishes, feelings and beliefs.

The Decision Maker should consult with **anyone engaged in caring for the person or interested in the person's welfare**. This would include family members and next of kin, as well as anyone else identified as being involved or interested in the person's care or treatment.

It may be that someone involved in the care of the person may not be appropriate to consult because of adult protection concerns or some other reason such as lack of willingness or availability to do so. In these cases, and if the other criteria are met, a referral should be made to the IMCA service.

Further guidance on 'Appropriate to Consult' is contained in:

[Cambridgeshire County Council Practice Guidance on the Use of the IMCA Service](#)

(Available on www.Cambridgeshire.gov.uk/Social/Mental)

[Speaking Up, IMCA Service, Guidelines for Referrers](#) (Available from www.speakingup.org and from Speaking Up IMCA Referral Line 0845 6500081).

The Decision Maker should also identify if there is someone with **the legal authority to make the decision**. If so, the decision should be deferred to those arrangements.

The Decision Maker should make reasonable efforts to consult with **anyone the person has named to be consulted**.

Consultation should not be limited to those people named by the person. There may be other relevant people such as neighbours and known friends could offer valuable understanding to regarding the person's wishes.

It should be remembered that a person might lack the capacity to make the decision and yet retain the capacity to name people they trust and would like to be involved in their care. If the person lacks the capacity to make a decision regarding consultation a best interests decision can be made in line with confidentiality and disclosure procedures (see section on Confidentiality on page 45).

The Consultation should cover what is known of the wishes, feelings and beliefs of the person who lack capacity, in relation to the decision. It should also include the opinion of the person being consulted regarding a best interests decision.

17 Best Interests Considerations (SOC 1708 / CPA 8 part 3.2)

The findings of the consultations, as well as any information known about the person that is relevant to the best interests decision can be summarised in section 3.2.

This section first of all asks whether there is a substitute legal arrangement such as LPA, deputy or advance ruling. If such an arrangement is in place, the course of action determined by the legal arrangement (the content of the ADRT, the judgment of the attorney or deputy) should be recorded here. The rest of section 3.2 should still be completed to document what is known of the person's best interests.

The remaining questions of section 3.2 allow for summaries to be recorded of what is known of the person's wishes and feelings and beliefs in relation to the decision. This would include the results of the consultations and particularly any indication of the

person's wishes in relation to the decision. For example, the person may have made it known that he or she would wish to consent to the treatment in question, or may have expressed a particular opinion about care homes.

It is particularly important to record any information regarding the person's cultural or spiritual identity, and their known belief systems. These will be integral to considerations regarding the less restrictive options.

There is space within section 3.2 to record any other factor relevant to the decision, such as the opinions of other professionals, the frailty of family carers, the opinion of family members, financial consequences to the decision etc. Record should also be made regarding whether or not the person is likely to regain capacity.

If a referral has been made to the Independent Mental Capacity Advocates, the findings of the IMCA report should be summarised in this section.

Best Interests Checklist (SOC1708 part 3.2) Decision maker should record:

- Whether there is a substitute legal arrangement, and the decision taken within it.
- What is known of the person's wishes, feelings and beliefs.
- Whether there is a record of preferences or Statement of Preferred Place of Care etc (Statement of preferences are not legally binding though should be followed where possible)
- The person's cultural identity and beliefs as they relate to the decision in question
- Other factors relevant to the best interests decision including the opinion of other professionals
- The findings of the IMCA report.

MCA Code of Practice provides clarification on the Best Interests Check List (Chapter 4)

18 Best Interests Decisions (SOC 1708 / CPA 8 part 3.3)

The Decision Maker should record the best interest decision and the reason why that decision most corresponds to the wishes, feelings, beliefs of the person who lacks capacity.

The Best Interests decision must also follow the principles of the Mental Capacity Act. The Decision Maker must demonstrate that the decision is less restrictive than other options and the one most protective of the person's overall autonomy.

The Decision Maker must defer to any relevant substitute decision-making arrangement that would reserve the legal authority to make the decision

The Decision Maker should also note other available options and record why they were discounted as not being in the person best interests.

If the IMCA service has been appointed, the Decision Maker must record how the decision relates to the findings within the IMCA report. The Decision Maker is also expected to inform the IMCA service of the decision.

The Decision Maker should have regard to whether capacity will be regained and whether the decision can be delayed.

In recording the Best Interests decision the decision maker should also make note of any potential disagreements and any steps taken to explain the decision to the person.

19 Counter Signing Assessments

The Capacity Assessment form includes space for the form to be 'signed off' by a senior member of staff or the relevant line manager. In Care Management situations line managers will be required to sign off capacity assessment forms and thereby endorse the assessment of the decision-making care manager.

Any capacity assessment for a decision requiring funding or panel approval will be returned if it has not been countersigned or completed appropriately.

20 Involvement of Carers

The Department of Health Booklet *Making Decisions: A Guide for family friends and other Unpaid Carers* is available on the Cambridgeshire County Council website: www.cambridgeshire.gov.uk/social/mental.

Someone with a relevant and registered power of attorney would have the legal authority to make the decision in question on behalf of the person who lacks capacity.

Anyone making a best interests decision will have to consult people involved in the person's care. The consultation should seek to establish the wishes and feelings of the carer, and what the carer believes to be in the best interests of the person. Wherever reasonable, the decision should be made in line with the carers' wishes.

There may be situations in which carers may disagree with the decision maker's assessment or best interests decision. All efforts should be made to seek resolution and explain the reasoning behind the best interests. A 'best interests' meeting can be held to explore the decision. If the carers still wish to question the decision they should be encouraged to use existing local complaints procedures, and ultimately, make an application to the court of protection. The court will decide whether or not to accept the application, and if so, will make a ruling on the decision.

If the decision maker has a reasonable idea about the best interests of the person who lacks capacity (in line with the best interests check list) then the decision can be made under the MCA. Carers who take autonomous action that is not considered by the decision maker to be in the person's best interests may subject to safeguarding adults procedures.

The IMCA service will not normally consider a referral when there is family or informal carer involvement unless there are exceptional circumstances that mean that the family members are not appropriate to be consulted.

The law does not define 'next of kin' and there are no legal restrictions on who can or cannot be someone's next of kin. Traditionally, hospitals have generally recognised spouses and close blood relatives as next of kin. However, the policy in most NHS trust is ask the patient to nominate next of kin, or, if the patient is unable to do this, the hospital will try to work out who is the person closest to the patient.

A next of kin has no legal liabilities, responsibilities or authority. Next of kin cannot consent to care or treatment on the person's behalf. Next of kin should be regarded as a 'voluntary' role and someone who is willing to be involved in the care and treatment of a person. In particular, the next of kin is identified as the person who staff should look to for guidance about someone's care and wishes. Next of kin should also be consulted about issues such as making funeral arrangements.

21 Self Funding Clients.

Self funding clients are also entitled to a capacity assessment when there is a reasonable doubt regarding a lack of capacity. The staff member most closely associated with the decision should undertake the capacity assessment (even if the decision is effectively taken by family members or someone with relevant power of attorney who decides to release finances for funding).

The decision nevertheless is still to be guided by the best interests principles of the MCA, including respecting the wishes feelings and beliefs of the person, and due consideration for less restrictive options. If it is thought that someone operating on behalf of a self funding client is not doing so in the person's best interests, then adult safeguarding procedures should be instigated.

A self funding client is also entitled to an Independent Mental Capacity Advocate, if the criteria are met (see below). The IMCA service will require a referral from the staff member undertaking the capacity assessment.

22 Independent Mental Capacity Advocates

The MCA recognises that there will be a group of people who lack capacity and have no one other than paid staff to represent them when a particular serious decision needs to be made. The MCA has created the role of Independent Mental Capacity Advocate to ensure that their rights and best interests are respected.

To determine whether a person is entitled to an IMCA two broad questions need to be answered:

1. Does the decision relate to one of the following
 - a. Serious medical treatment, or
 - b. Long term accommodation change, or
 - c. Adult protection proceedings, or
 - d. Care review?

AND

2. Does the person
 - a. Lack capacity to make the decision in question and
 - b. Have no one else appropriate to consult?

If the answer is 'yes' to both then the person has a right to an IMCA and a referral to the IMCA service does need to be made.

The MCA is clear that, when the conditions are met, the person has a right to an IMCA. This right is not to be restricted to complex or sensitive decisions: an IMCA must still be instructed even if the decision is simple and straightforward and the person is compliant.

Serious Medical Treatment and Long Term Accommodation Change

The MCA makes it a specific legal duty to instruct an IMCA if the decision regards serious medical treatment or long-term accommodation change (and the person lacks capacity and has no-one else appropriate to consult). Failure to refer to the IMCA service in these circumstances could be viewed as a serious breach of the MCA.

Serious medical treatment is defined as “treatment, which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered” (Code of Practice 10.43) and where what is proposed is likely to have serious consequences. Further guidance is contained within the Code of Practice Chapter 10.

Long term accommodation change is regarded as a move into or between care of more than 28 days in hospital (i.e. a stay in hospital for care rather than treatment) or more than 8 weeks in a care home. A referral should also be made when an interim or respite arrangement goes beyond 8 weeks.

Accommodation arrangements made under section 177 of the Mental Health Act 1983 would also require an IMCA referral.

Involvement of an IMCA in adult protection proceedings.

The Mental Capacity Act specifies that Local Authorities and the NHS have discretionary powers to instruct an IMCA where protective measures are being put in place in relation to the protection of vulnerable adults from abuse.

All Adult Protection strategy meetings should consider if a referral should be made to an IMCA. An IMCA can be instructed in an adult protection process whether or not there is someone appropriate to consult.

If the decision relates to the capacity to understand the safeguarding proceedings themselves, then the referral should be made by the POVA lead. The referral would need to be supported by a capacity assessment. The referral in these circumstances would be required at, or before, the strategy discussion stage, particularly when the person’s decisions or actions would impact on the investigation, or when immediate safeguarding action is required.

A referral can also be made at the strategy meeting stage when decisions may be made as a result of the investigation. These decisions may fall into the statutory IMCA decisions (especially accommodation) in which case a referral to the IMCA service should be made by the person who takes over the responsibility for that decision (this may or may not be the POVA lead).

It is therefore possible, and likely, that more than one referral may be made to the IMCA service during the course of the POVA proceedings. This recognises the decision specific nature of the MCA and will also maintain clear communication between the decision makers and the IMCA.

Staff seeking further guidance on the Safeguarding process should refer to Cambridgeshire County Council’s policy document

Protection of Vulnerable Adults from Abuse/Safeguarding Adults, Practice Guidance and Procedures, March 2008

available on <http://www.cambridgeshire.gov.uk/social/adultprot/schvagforoagen.htm>.

Involvement of an IMCA in care reviews

When there is a review of care needs for residents in a care home or NHS funded care an IMCA can be instructed to represent a person who lacks capacity within the review and there is no one else appropriate who could be consulted.

An IMCA should be considered in a review of care needs for residents in a care home or NHS funded care, including self funding service users, if

- An IMCA was involved in the initial placement
- An IMCA would have been involved in the initial placement but it was arranged as an emergency placement.
- The person was placed in the accommodation before April 2007 (when the Mental Capacity Act came into force) and lacked the capacity to agree to the accommodation.
- The person has lost capacity since being placed in the accommodation.
- There is a disagreement on how the person's needs can be met in the future.
- The review is likely to instigate a long-term change in the person's accommodation.

In both care reviews and adult protection cases the decision to instruct an IMCA is discretionary. However, there is a duty on each occasion to decide whether or not it is necessary to appoint an IMCA.

'Appropriate to consult'

The starting point under the Mental Capacity Act is to involve and include family members, friends and informal carers. The Act recognises the right of carers to be involved in decisions taken on behalf of the cared for person. The decision maker should ensure that all reasonable attempts have been made to keep the informal carers involved.

Staff considering whether or not there is someone 'appropriate to consult' should refer to the guidance offered by Speaking Up, the providers of the IMCA service in Cambridgeshire.

The IMCA service is **not intended as a mediation service**. The service was created to support people who are, so to speak, 'unbefriended' and this is still its primary focus.

The IMCA service would not normally accept referrals where there is family involvement, and not where the family simply disagree with a course of action. These disagreements may be resolved in other ways such as a best interests meeting, a referral to a generic advocacy service or through local complaints and resolution procedures.

To instruct an IMCA when there is disagreement that involves family, the decision maker is essentially stating that the family is, by disagreeing, no longer appropriate to be involved in the decision. It is also the decision maker's responsibility to communicate this to the family member. In practice, there should be very few situations when this is the case and there are no safeguarding concerns raised.

All reasonable steps to resolve the situation must be shown to have been taken before an IMCA can become involved in a situation where family or friends would otherwise be expected to be involved.

IMCA access to records.

Under section 35(6)(b) of the Mental Capacity Act, an IMCA, once instructed, has the right to examine and copy any records the person holding the record regards as relevant to the decision. The relevance will depend on the decision in question and could include clinical records, care plans, social care assessments or care home records. The decision maker should normally agree with the IMCA the information to be seen. If this includes third party information, contact should be made with the person responsible to access to records request.

Disagreements between the decision maker and an IMCA.

As the person's representative the IMCA has the same rights to challenge a decision as anyone else involved in the person's care and welfare. If a disagreement occurs between the decision maker and an IMCA, they should seek resolution themselves in the first instance. If disagreement continues, the respective line managers should become involved to find a way forward. If the situation remains unresolved it should be referred to the Cambridgeshire IMCA steering group for consideration.

IMCA and Generic Advocacy

As the requirement for an IMCA is a legal duty, there may be situations when there is an IMCA as well as general advocate involved in a person's care or treatment. The IMCA has a specific legal remit and anything outside of this remit may require the support of general advocacy. Information on advocacy within Cambridgeshire is provided on the County Council website:

<http://www.cambridgeshire.gov.uk/social/accessing/ascadvocacy.htm>

General advocacy services can take clients without capacity, even if befriended. The Citizen's Advice Service can also offer independent legal advice.

Further Guidance

Staff who believe that a situation will require an IMCA should make a referral to the Speaking Up IMCA service, which provides IMCAs in Cambridgeshire. Contact can be made by telephone, letter or fax or email. The IMCA service will then request a completed Speaking Up IMCA referral form.

Speaking Up also offer an IMCA referral line through which staff can discuss potential IMCA involvement.

Speaking Up IMCA Referral line:	0845 650 0081
Speaking Up IMCA email:	imca@speakingup.org

Further guidance on the IMCA service can be found at:

www.speakingup.org/imca

www.cambridgeshire.gov.uk/social/mental

Code of Practice chapter10.

23 Lasting Powers of Attorney

Lasting Powers of Attorney replace enduring powers of attorney (EPA). Existing EPAs will be remain valid though no more will be made.

There are two types of LPA:

- Property and Affairs LPA
- Personal welfare LPA.

A Lasting Power of Attorney cannot be used until it has been registered and stamped by the Office of Public Guardian.

Property and Affairs

Both the donor and the donee (i.e the attorney) must be over 18. Property and affairs attorneys may be not be undischarged bankrupts.

While the Mental Capacity Act itself does not specify the areas covered by a property and affairs LPA, examples listed in the Code of Practice include:

- Buying and selling property
- Dealing with tax affairs
- Investing savings
- Applying entitlement to NHS or social care entitlement.
- Claiming, receiving and using benefits
- Operating bank accounts
- Paying outgoings
- Making gifts

The donor may choose to make arrangements so that the attorney has the authority to make decisions regarding property and affairs even though the donor keeps the capacity to make them.

Personal Welfare Powers of Attorney

Someone with a Personal Welfare LPA will be able to give or refuse consent to health care or treatment or a social care decision. This will enable health care staff to provide a person who lacks capacity with treatment with consent.

The MCA placed specified conditions on Personal Welfare LPA:

- The LPA extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care.
- Applies only to circumstances when the donor lacks the capacity to make the decision in question.
- Is subject to an Advance Decision to Refuse Treatment if the ADRT has been made after the LPA.
- Does not authorise the giving or refusing of consent to life sustaining treatment unless express provision is given to that effect.

Aside from health and medical treatment the scope of the Personal Welfare LPA is not defined in the act itself, although the Code of Practice includes:

- Decisions about where the donor should live
- Who may have contact with the donor
- Day to day care
- Rights of access to personal information about the donor
- Whether the donor should take part in social activities, leisure activities, education or training

The Donor

The person taking out the power of attorney is known as the donor. The donor may specify the types of decisions the attorney is authorised to make and may place conditions on the attorney (such as a duty to consult with a named other). The donor

may also exclude certain decisions. If the types of decisions are not specified then the LPA is taken to cover all decisions.

The donor can appoint more than one attorney. The attorneys can be appointed to act jointly (in consensus) or severally (each one has individual authority for specified decisions). Someone with Property & Affairs LPA does not have authority to make personal welfare decisions (unless they also hold separate LPA authority).

The Attorney

The attorney may only take those decisions authorised in the LPA and only when the donor has been assessed as lacking the capacity to make the particular personal welfare decision at the material time when it is required.

This assessment would be a matter for the professional with responsibility for the decision (rather than the attorney).

If the donor does lack the capacity to make the decision, then the attorney will have the authority to make it as long as the decision is authorised in the LPA. The attorney is able to give or refuse consent to medical treatment. The attorney's decision is, to all intents and purposes, that of the donor.

An attorney must...

- Act according to the MCA code of practice.
- Have a duty of care in decision making, to carry out donor's wishes and respect confidentiality.

Limits

- Attorney cannot request or require treatment.
- Attorney cannot consent to or refuse treatment for a mental disorder in respect of a formally detained patient (but can for treatments for physical conditions and for mental health treatment not regulated by section 4 of MHA. The attorney can also object to ECT treatment)
- Attorney cannot make decisions which conflict with those of a Guardian if donor is under Guardianship order
- Decisions in respect to family relations including consent to marriage or civil partnerships, sexual relations and parental responsibilities.
- Decisions in respect of voting rights.

There is a charge for registering an LPA with the Office of Public Guardian (currently £150 as of January 2009). Users of the services may be eligible for an exemption or remission of the fees for registering an LPA. Further details can be found on the Website of the Office of the Public Guardian.

Staff are encouraged to ask to see the form granting Lasting Powers of Attorney. The form needs to have been stamped on every page by the Office of the Public Guardian to be a legal document. The form should also specify the decisions the Attorney is entitled to make on behalf of the person. An Attorney can only make a welfare decision when the person has been assessed as lacking the capacity to make it.

The LPA form must be registered with the Office of Public Guardian (OPG) before an Attorney can exercise the legal authority to make decisions on behalf of the donor.

If information on whether or not there is an LPA in place cannot be gained in any other way, an application can be made to the office of the Public Guardian for a search of the register of attorneys. (There is a small charge for this, £25 as of January 2009).

Court of Protection & Office of Public Guardian.

Court of Protection, through the Office of Public Guardian, exercises jurisdiction over attorneys. This includes:

- Deciding whether the formal requirements of the MCA have been met.
- Deciding whether fraud or undue pressure has been exerted in the creation or execution of an LPA.
- Deciding on the meaning or effect of an LPA.
- Giving authority to the attorney to make decisions which fall out of the LPA

The Attorney is bound by the MCA code of practice and must make decisions that are in the donor's best interests following the best interests checklist in section 4 of the MCA. If healthcare professionals disagree with the attorney's decision they may apply to the court of protection and give life-sustaining treatment in the meantime while the court decides the matter.

Certificate of capacity

To safeguard the donor the LPA must contain a certificate given by a person of prescribed description stating that in his or her opinion

- The donor understands the purpose of the LPA and the scope of authority given under it.
- No fraud or undue pressure is being used to induce the donor to create an LPA.
- There is nothing else which would prevent the LPA being created.

There are two groups of people who can sign the certificate of capacity.

Group A ("Knowledge based" providers): Someone who knows the donor personally and has done so for at least two years.

Group B ("Skills based providers): Someone chosen by the donor and who considers that they have the professional skills and experience to certify the LPA.

Some suitable skills based professionals would include:

- Registered healthcare professionals
- Barrister, solicitor or legal advocate
- Registered Social Worker
- An Independent Mental Capacity Advocate
- Someone who considers themselves to have the relevant professional skills and experience.

Staff are not required to provide certificates as part of their contract of employment and should advise those requesting a certificate of capacity to go to a solicitor or the Citizen's Advice Bureau.

Implications for health and social care staff

- Would need to be satisfied that the LPA has been registered with the OPG (ie stamped on every page).

- Would need to be satisfied that that the LPA does cover the decision in question.
- Would need to assess capacity to give or refuse consent for the treatment decisions which lie within their responsibility
 - This could then trigger the involvement of the attorney
 - The medical professionals should not be asked to assess capacity for decisions that do not lie within their own responsibility (unless requested to do so under the LPA conditions)
- May need to challenge the decision taken by an attorney, if there are reasons to be believe that it is not in the person's best interests.
 - The MCA best interests checklist recognises that best interests must reflect the known wishes, feelings and values of the person, and confers a duty to consult with family members and carers.

Details of the LPA application forms and supporting documents can be found at www.publicguardian.gov.uk . Further details on the arrangements and responsibilities associated with LPAs can be found in the Code of Practice chapter 7

24 Enduring Power of Attorney

Enduring Powers of Attorney were made before the MCA. All existing EPAs will continue to be made effective under the same basis as they were made. EPA apply to property and affairs decisions. They need to be registered at the point when the person is assessed as lacking capacity.

Mental Capacity Act 2005 Code of Practice Paragraph 7.5

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

25 Roles of Court Appointed Deputies and the Court of Protection

The Mental Capacity establishes a new Court of Protection and extends its powers and scope. It is the same powers, rights, privileges and authority as the High Court. The Court of Protection can deal with any issue concerning people who lack capacity. This could involve

- Making a declaration about whether or not a person has capacity to make a particular decision.
- Making a decision on serious issues about health care and treatment
- Making decisions about the property and financial affairs of a person who lacks capacity
- Appointing deputies to have an ongoing authority to make decisions
- Making decisions in relation to LPAs and EPAs.
- Hearing a challenge from an IMCA that a decision maker had failed to take the IMCA report into consideration as to what was in the best interests of a person.

Court Appointed Deputies

The previous Court of Protection appointed receivers to manage the ongoing property and affairs of a person who lacked capacity. The new Court of Protection, established under the Mental Capacity Act 2005, replaces receivers with the role of 'deputy'. A deputy can be appointed in respect of property and affairs and/or personal welfare issues. Deputies, like people with powers of attorney, must have regard to

the Code of Practice and act in the person's best interests as laid out in the Code of Practice.

Local Authority Office Holder as Deputy

Where there is no one else who could act on behalf of the person who lacks capacity to make the decisions in question, the Court could appoint a specified office holder within the Local Authority as a deputy. The previous Court of Protection took this route and appointed receivers in Local Authorities many times.

The deputy should hold a senior office within the organisation. The deputy can delegate specific tasks to operational staff. The deputy is still responsible for actions or decisions taken. The Court of Protection should not appoint an operational staff member as a deputy for someone receiving Local Authority services.

Operational staff can instigate the application to the Court of Protection for the Local Authority Office Holder to be appointed as a deputy. Court of Protection applications should be a route of 'last resort' and will only be considered when there are no family members or friends who are willing to seek the authority to act on behalf of the person.

If the Court of Protection grants an application, the service user needs to be kept involved in the decisions made on their behalf. This should be clearly documented in the case notes and care plans. Decisions made through a deputyship arrangement must follow the best interests considerations set out in section 4 of the MCA and chapter 5 of the Code of Practice.

The person's care plan and records of any review to it should be sent to the post holder named as the deputy.

The Office of the Public Guardian supervises all deputyship arrangements.

The Public Guardian and the Office of the Public Guardian.

The Mental Capacity Act creates a new public office known as the Public Guardian, supported by the Office of the Public Guardian. The functions of the Public Guardian include:

- Maintaining registers of LPAs and court-appointed deputies.
- Supervising deputies
- Directing Court of protection visitors to visit and report on LPA attorneys, deputies or the person who lacks capacity.
- Receiving reports from deputies or attorneys
- Providing reports to the Court of Protection
- Dealing with complaints about the way in which attorneys or deputies are exercising their powers.

Separate guidance on applications to the Court of Protection is available.

26 Advance Decisions to Refuse Treatments

An advance decision to refuse treatment enables someone over 18 to state what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to the treatment at the point in the future when it is proposed.

When a person has made an advance decision to refuse treatment that it is valid and applicable to the circumstances, it must be regarded as having the same legal force as a refusal made by a person with capacity.

An advance decision to refuse treatment must be **valid**. The person must not have withdrawn it, or over-ridden it by subsequently making a LPA that relates to the treatment in the advance decision, or acted in a way that is clearly inconsistent with the advance decision (for example by consenting to the treatment while having capacity)

An advance decision to refuse treatment must be **applicable**. It must relate to the treatment in question and explain the circumstances under which it is to be refused.

Advance Decisions to Refuse Life Sustaining Treatment

Where it relates to a refusal of life sustaining treatment, an advance decision has to be in written, signed, witnessed and must include a statement such as 'even if my life is at risk'. It can be signed on the maker's behalf at their direction if he or she cannot sign it for himself or herself.

Conscientious objection

A staff member who objects in conscience to following an advance decision to refuse life-sustaining treatment is protected by the European Convention on Human Rights from doing something that goes against their beliefs. The staff member should make their objections known as soon as possible and arrangements must be made for the management of the patient's care to be transferred to another health professional.

Liability of health and social care staff.

If staff are reasonably satisfied that there is a valid and applicable advance decision to refuse treatment they will not be held liable for the consequences of abiding by it by not providing the treatment in question.

If staff are satisfied that there is a valid and applicable advance decision and do not abide by it, they could face a legal claim for damages or a criminal prosecution for assault.

No liability will be incurred by staff providing treatment in a patient's best interests unless they are satisfied that a valid and applicable advance decision exists, in which case there is a legal expectation that the advance decision will be followed.

Limitations to Advance Decisions to Refuse Treatment

- Where people are detained under the Mental Health Act 1983, they can be given treatment despite having refused it in an advance decision. The only exception to this would relate to an advance decision to refuse Electroconvulsive Therapy (ECT), which would still hold even if the person were detained under the Mental Health Act (as amended by the 2007 Mental Health Act).
- People cannot make an advance decision to ask for their life to be ended.
- People can only make an advance decision to refuse treatment, not to request it. Statements that indicate requests or preferences of treatment or care arrangements must be taken into account when considering a decision to be taken in the person's best interests. However, the statement or request itself is not legally binding.

Further information on Advance Decisions is available on www.adrtnhs.co.uk

27 Finance

Within Cambridgeshire County Council, the management of a person's finances is administered by Adult Services.

Staff handling the finances of a service user who lacks capacity to manage them should follow the procedures laid out in the *Handling Client's Finances*.

Direct Payments and Individualised Budgets

It is important that vulnerable people achieve access to the opportunities for independence offered by Direct Payments and Individualised Budgets. The principles of the MCA should direct staff to encourage and assist people to be able to choose Direct Payments or Individualised budgets. Care should be taken where people may have fluctuating capacity to make decisions and to consent to financial arrangements.

The legislation governing Direct Payments and the associated 2003 Department of Health Guidance preclude an incapacitated person from signing a financial agreement for Direct Payments, although an EPA and LPA or Deputy with the relevant authority can make the arrangements on the person's behalf. However, the 2007 Health and Social Care Bill introduces the ability of a 'suitable person' to set up and administer Direct Payments for someone lacking capacity to consent. Direct Payments should be set up following the operational instructions on Direct Payments. Payments made to a Third Party or Agent or to a 'User Controlled Trust' are indirect payments and therefore there is no duty to ensure capacity to consent.

Further information on direct payments can be found on Cambridgeshire County Council's website:
<http://www.cambridgeshire.gov.uk/social/accessing/schascadirectpay.htm>

28 Restraint

Restraint, as defined in the Mental Capacity Act, occurs when someone 'uses, or threatens to use, force to secure the doing of an act which the person resists, or restricts the person's liberty of movement whether or not the person resists' (Mental Capacity Act 2005 6(4)). This would therefore include verbal threats, physical restraints, holding the person down, locking the person in a room or using sedation as a means of restraint.

Section 6(1) of the MCA specifically limits the protection from liability ordinarily provided by section 5 MCA when restraint is considered. Protection is only available when there is a reasonable belief that the restraint is necessary to prevent harm to the person and that the restraint is proportionate to the likelihood and seriousness of the harm.

The Code of Practice (paragraphs 6.11, 6.39-6.48) gives further guidance. The emphasis falls on the person carrying out (or authorising) the restraint to identify the reasons to justify it: i.e. the likelihood and seriousness of harm, and the reasons why the restraint used is considered as the most proportionate and least restrictive way to protect the person from that harm.

The restraint guidance does not apply to those individuals who lack capacity and who may need to be deprived of their liberty. These people will come under the deprivation of liberty safeguards

29 Transport and Conveyance

In almost all cases a person could be lawfully conveyed under the MCA if it is considered being in their best interests to be in the care home or hospital. The conveyance of a person who lacks capacity to consent from their home, or another location, to a hospital or care home would not usually amount to a deprivation of their liberty. Even if there is an expectation that the person will be deprived of their liberty in the care home or hospital it is unlikely that the journey itself would constitute a deprivation of liberty

Health and social care professionals, police and ambulance personnel need to have evidenced that they have taken reasonable steps to ascertain capacity to consent to conveyance and best interests reasons requiring it, unless in cases of urgent necessity. In general there is no impediment under the MCA or other law to conveying people who lack capacity as long as it is done to prevent harm and that it is proportionate to the seriousness of harm.

This may include the need for the conveyance and the long-term harm that would be risked if the conveyance did not take place.

Individual agency policy about conveying vulnerable people in worker's own cars should be followed. An in-compliant person who lacks the capacity to consent to being conveyed should not be moved in a worker's own car without a strong reason to do so and not without an accompanying management plan.

Other workers may need to travel with the person to provide additional safeguards, particularly when the circumstances are more serious, for example, the arrangements to move someone into a care home may need to be more thorough and considered than those for a visit to a care facility.

Staff using Cambridgeshire social service transport should follow the *Use of Social Services Department Transport* and use SOC978 to request the transport. The form should include statements regarding the capacity of the service user and the best interests reasons for requesting the transport.

Police and ambulance staff moving a person lacking capacity to consent may do so if they have a 'reasonable' belief that the person lacks capacity and should be moved in their best interests.

There are exceptions to this in cases of people under the processes of the mental health act, or under the powers of other police processes. People cannot be transported for treatment if they have made a valid and applicable advance decision to refuse the treatment in question.

There may be very unusual circumstances, perhaps where it is necessary to do more than persuade or restrain the person for the purpose of conveying, or where the journey is exceptionally long, when the transportation may amount to a deprivation of liberty. A Court of Protection order may be necessary to provide extra protection to the individual. The Deprivation of Liberty safeguards would not be necessary for these situations.

30 Research Involving People who Lack Capacity to Consent.

Staff may be asked to become involved in research projects in which the people they are providing with care or treatment are taking part. If the person lacks capacity, the research must follow several safe guards introduced by the mental capacity act.

- Researchers must identify individuals who are independent of the research project to provide advice on the participation in research by a person who lacks capacity. In the first instance, this should be family members and/or unpaid carers.
- Where a person who lacks capacity shows signs of being unhappy about being involved in the research, the research will not be allowed to continue.
- All plans for research will be checked by a recognised independent Research Ethics Committee.
- The committee will need to agree that the research is necessary, safe and appropriate and cannot be done as effectively using people who have capacity.
- The committee will also have to approve dealings with people who consented to join a long-term research project but lost the capacity before the end of the project.

Anyone setting up or carrying out such research will need to make sure the research complies with the provisions set out in the Act and follow the guidance given in the Code of Practice.

31 The Mental Capacity Act and Children and Young People

The Mental Capacity Act applies to people over 16. There are a small number of exceptions:

- Lasting Powers of Attorney only apply to people over 18.
- Only people over 18 can make an Advance Decision to Refuse Treatment
- The law generally does not allow people under 18 to make a will. The MCA confirms that the Court of Protection has no power to make a will on behalf of anyone under the age of 18 years.
- The Court of Protection has powers to make decisions concerning the property and affairs of a child under the age of 16.
- There is no specified age limit relating to the age of a victim of a Criminal Offence of Ill treatment or Neglect.

There is an overlap between the MCA and the Children's Act for 16 or 17 year olds. There is cross jurisdiction between the Court of Protection and the Children's Court. Decisions should be made under the Mental Capacity Act if it is considered that the issues relating to the lack of capacity will continue beyond the young person's 18th birthday.

The legislation relating to Children and Young People is already quite complex, and consideration should be given in each individual case as to which legislation should be applied.

However, some broad distinctions can be made:

Young people with capacity aged 16 & 17 can consent to treatment. The consent of a young person must be regarded as if he or she was of full age, and therefore cannot be overridden (for example a parent cannot refuse treatment to which the young person has consented).

There is legal scope to override a young person's refusal of treatment, either via the court or by someone with parental responsibility. However, this is increasingly unlikely in practice, as there would need to be strong reasons why the young person's wishes were not respected. The Mental Health Act 1983 (as amended by the 2007 Mental Health Act) recognises a young person's right to refuse treatment.

Young people over 16 who lack capacity can be treated under the mental capacity act.

A child under 16, with 'competence', can consent to treatment but not refuse it. Someone with parental responsibility can consent to treatment if the child refuses. If the parent also refuses the treatment, it can still be provided under the direction of the Children's Court.

Someone with parental responsibility can consent on behalf of child under 16 who lacks capacity. If the parent refuses the treatment, it can still be provided under the direction of the Children's Court.

In cases involving young people who lack capacity, the authority of the decision may fall to someone with parental responsibility. This would be:

- Child's Parents if married at time of conception / birth.
- Mother
- Father if married to mother. If unmarried, then if named on child's birth registration (after December 2003), otherwise only via court order or a parental responsibility order or the couple subsequently marry.
- Legally appointed guardian (appointed by court or specified in will & testament of parent with parental responsibility)
- Person in whose favour a court has made a Residence Order or a Special Guardianship.
- A local authority designated in care order (but not where the child is being looked after under section 20 of Children's Act.)
- Local authority or other authorised person holding emergency protection order in respect of the child.
- Foster parents and grandparents do not automatically have parental responsibility
- Parents under 16 needs to have 'Gillick' competency to have parental responsibility

32 The Mental Capacity Act and the 1983 Mental Health Act (as amended by the 2007 Mental Health Act).

The MCA may be used to treat people for a mental disorder when they cannot consent to treatment because they lack capacity, providing that the treatment is in the person's best interests. The fact that a patient may not be able to consent to treatment or admission does not automatically mean that the MHA must be used.

The MCA should be considered in the first instance when the person is not objecting to the admission or mental health treatment; it then maybe undertaken under the MCA. However the MCA cannot be used as an alternative to admission where the criteria for the MHA apply i.e. when a patient does objects or where, from the knowledge of the patient, it is likely that the person would object.

Where it is thought people might need to be detained for treatment for a mental disorder, an assessment with a view to detention under the Mental Health Act should be considered.

Treatment or care that is not provided under the formal powers of the Mental Health Act is subject to the MCA: the MCA applies to someone detained under the MHA who requires treatment for a physical condition unrelated to his or her mental health problem.

After April 2009, it may be possible to provide treatment under the MCA even if the provision of the treatment deprives the person of their liberty. Deprivation of liberty for the purposes of care or treatment in a hospital or care home can be authorised in the person's best interests under the MCA if the criteria for the deprivation of liberty safeguards are met.

Detained Persons

The MHA takes priority over the MCA in relation to powers of treatment for mental disorder under Part IV of the MHA. Therefore it is possible to provide treatment under the MCA to people who are detained under MHA section 4, 5(2), 5(4), Sec 7. Sec25a, Sec135, Sec 136.

An IMCA is not required for formal admissions to hospital under the MHA or to a care home under Guardianship, supervised discharge, supervised community treatment or section 17 leave.

Accommodation arrangements made under section 117 of the Mental Health Act would require an IMCA if the conditions are met (see above section 20).

Nearest Relative powers remain and are distinct from LPA or Deputy.

People in Mental Health Wards who are not detained under the MHA

People who are in Mental Health Hospital wards and are not detained under the Mental Health Act can be treated under the Mental Capacity Act. The MCA can provide protection from liability provided that the best interests principles of the act are complied with and the MHA does not apply.

The MCA and the IMCA service can apply to mental health treatment that is not provided under the MHA.

Guardianship

In general decisions and arrangements regarding the residential care of a person who lacks capacity can be made under section 5 of the Mental Capacity Act or under a relevant power of attorney or deputyship. It will not always be best to use guardianship as the way of deciding where patients who lack capacity should live. In cases that have unusual or exceptionally complex issues it may be preferable to seek a best interests decisions from the court of protection.

Guardianship under the Mental Health Act may be more appropriate when it is thought necessary for the person to reside in a named place in the interests of his or her welfare or for the protection of others and particularly if one person or authority is best placed to make decisions.

Lasting Powers of Attorney

In general, the validity and scope of any Lasting Power of Attorney or deputyships are not affected when a person is subject to the Mental Health Act.

There are two main exceptions:

- An attorney or a deputy cannot consent on a patient's behalf to treatment regulated by part 4 of the MHA, including neurosurgery for mental disorder and other treatments under section 57.
- An attorney or a deputy will not be able to take decisions about where a patient subject to guardianship is to live, or to take other decisions which conflict with decisions that a guardian has a legal duty to make.

An attorney or a deputy can object to ECT treatment (following amendments made by the MHA 2007).

People subject to compulsory measures under the MHA can still make new LPAs if they have the capacity to do so. Likewise, the Court of Protection can also appoint a deputy for a person subject to compulsory powers.

If an attorney or deputy takes a decision on the patient's behalf that goes against one of the conditions imposed through supervised community discharge or conditional discharge, then the patient will be taken to have gone against the condition. This might result in the patient's recall to hospital being considered.

Personal Welfare attorneys and deputies may be able to exercise a patient's rights to apply to the Tribunal for discharge from detention, guardianship or SCT.

Advance Decisions to Refuse Treatment

A patient may make an advance decision refusing treatment for a mental disorder. There may be occasions therefore, when the only way to ensure that they get the treatment they need (which they have refused in the advance decision) is to detain them under the Mental Health Act.

A patient detained under the MHA or subject to supervised community treatment can be provided with treatment without their consent and even though they have made a valid and applicable advance decision to refuse to the treatment. The only exception, made by the MHA 2007, is for ECT treatment: a valid and applicable advance refusal of ECT treatment would hold.

Clinicians providing compulsory treatment under the MHA should try to comply with the wishes expressed in an advance decision, for example considering if a treatment other than that refused in the advance decision could be given.

The MCA code of practice chapter 13 contains further guidance on the interface between the MCA and the MHA.

33 Deprivation of liberty safeguards.

Deprivation of liberty safeguards (DOLS) were introduced into Mental Capacity Act 2005 (MCA) through the Mental Health Act 2007. They are intended to prevent arbitrary decisions that may deprive vulnerable people of their liberty.

If a person does need to be deprived of their liberty then the safeguards will give them and their representatives rights of appeal and will ensure that the deprivation will be reviewed and monitored.

The Safeguards cover people in hospital and care homes registered under the Care Standards Act 2000 and will become a statutory obligation in April 2009.

The DOLS procedures ask two fundamental questions:

1. Is the person being deprived of his or her liberty?
2. If so, is the deprivation of liberty in his or her best interests?

Deprivation of liberty applies only to Registered Care Homes and Hospitals. The Care Home or Hospital is known as the 'managing authority' because it will have to manage the deprivation of liberty once it has been authorised.

If the deprivation is in the person's best interests, the managing authority must apply for it to be authorised by the 'supervisory body': this would be the Local Authority for care homes or the PCT for hospital settings. A person must not be deprived of liberty unless an authorisation has been given by the supervisory body, or, in urgent cases, authorisation has been sought.

If the deprivation of the person's liberty is not in his or her best interests the arrangements must be changed or further action may be taken, including legal action.

Deprivation of Liberty only applies to people over 18, have a mental disorder as defined by the Mental Health Act 1983 and who lack the mental capacity, as defined by the Mental Capacity Act 2005, to make decisions regarding their care or treatment arrangements.

There are important distinctions to be made between a **restriction of liberty** and a **deprivation of liberty**

The key issues when determining deprivation of liberty are to consider the level of control over the person and the intensity with which it is used. Deprivation of Liberty could occur when "complete and effective control" is taken over the person. There is, however, no one single defining factor that distinguishes a restriction of liberty from a deprivation of liberty.

Restrictions of liberty

The following factors may restrict a person's liberty. Each one may be in a person's best interests if it has been recorded that it is proportionate to the harm that the person's faces, and is the least restrictive way of protecting the person from that harm. Each on its own would not constitute a deprivation of liberty. The list is not exhaustive.

- A locked ward
- Keypad / double door locks
- Bringing back a person who has wandered
- Benign force is used to bring a confused person back to the care home or hospital
- Placing reasonable limitations on visiting by carers

- Refusing to let a person leave the facility without an escort whose job it is to care for / support the person.

Each of the following situations on its own may be also considered a **restriction of liberty**, though not in the person's best interests. A combination of several such situations may build up to indicate an over-riding **deprivation of liberty that would be unlikely to be in a person's best interests**:

- The person is left in the same chair / communal area without a variety of stimulation or interaction being offered to them.
- The person is not being facilitated to leave the premises (eg for walks, visits to shops etc)
- Restraint (including sedative medication) is being used on a regular and repeated basis.
- The person is being left in his or her room for long periods without meaningful interaction or the opportunity to go elsewhere on the premises.
- Connecting doors *within* the premises are locked
- The person is not given a choice regarding meals; clothing; bathing.
- The person is being restrained or restricted as a means of punishment or is threatened with such
- There is a restriction of choice over the use of communal space
- The person is subject to communal music / television without the reasonable possibility to influence its selection or of being moved away from it.
- Restrictions are put in place that limits the contact between the person and their family and friends.

This list is not exhaustive and a lack of resources or staff cannot be used to justify any such deprivation of liberty.

Deprivations of liberty that are not in the person's best interests are likely to be unlawful. Any interested part can make a request to the Supervisory Body to assess whether unlawful deprivation of liberty is occurring. The Assessment must be carried out within 7 calendar days.

It is unlikely that authorisation will be granted in these circumstances. This means that there could be further action taken, including prosecution, if changes are not made.

Deprivation of Liberty in the Person's Best Interests.

Deprivation of liberty can be authorised by the supervisory body if it is the person's best interests. This means that a deprivation of liberty is an unavoidable way of protecting the person from serious harm.

There are some questions to guide

1. What is the seriousness and likelihood of the harm facing the person?
2. Is the deprivation of liberty proportionate to the risk of harm?
3. Is there a less restrictive way of protecting the person from the harm?

The potential harm would need to be great for a person to be deprived of his or her liberty. The deprivation of liberty would also need to be the least restrictive option; that is, the person could not be protected from harm in any other reasonable way.

Chapter two of the Deprivation of Liberty Code of Practice states that “The question of whether the steps taken by staff or institutions in relation to a person amount to a deprivation of that person’s liberty is ultimately a legal question, and only the courts can determine the law”

In practice, what constitutes a deprivation of liberty may only become apparent when the DOLS trained professional assesses all the person’s situation and best interests.

In care home settings this may apply to situations in which the person has little or no active choice regarding care and accommodation decisions, including little or no choice of being admitted and kept in care.

DOLS Assessments

When a person needs to remain in a care home or hospital in order to receive the care or treatment that is necessary to prevent harm occurring and there are reasons to believe that he or she will need to have to be deprived of his/her liberty...

The **Managing Authority** (The care home / hospital) will need to apply to the Supervisory Body for authorisation to deprive the person of his/her liberty.

The **Supervisory Body** (PCT or LA) will assess each individual application for authorisation and will provide or refuse authorisation for Deprivation of Liberty for a specified time limit which will be no more than twelve months. .

The Managing Authority should request authorisation when it appears that a person accommodated by the managing authority will be deprived of liberty sometime within the next 28 calendar days.

The assessment process must be completed within 21 calendar days of receiving the request.

If it is necessary to deprive the person of liberty before the assessment process can be completed, the Managing Authority can give itself Urgent Authorisation. This can be for up to 7 days and must be accompanied by an application for standard authorisation. Urgent Authorisations can be extended only by the Supervisory Body and only for up to a further 7 days.

The **DOLS assessment** process has 6 elements:

1. **Age assessment** to establish person is 18 or over.
Assessed by DOLS Administrator or Best Interests Assessor
2. **Mental Capacity assessment** to establish whether the person lacks the capacity to consent to the care / treatment arrangements in a hospital or care home.
Assessed by Best Interests assessor
3. **No Refusals assessment** to establish whether a DOLS authorisation would conflict with other existing relevant legal decision making authority arrangements exist for the person (e.g. Powers of Attorney or an advance decision to refuse treatment)
Assessed by Best Interests Assessor
4. **Eligibility assessment** to establish whether the person is covered by the MHA or the MCA DOLS

Assessed by Best Interests Assessor or 'Section 12' (MHA) doctor.

5. **Mental Health assessment** to establish whether the person has a mental disorder within the meaning of the MHA 1983 and how the person would be affected by a deprivation of liberty.

Assessed by 'Section 12' doctor having completed approved DOL training

6. **Best Interests Assessment** to establish whether a DOL is occurring or going to occur and if so, whether it is the person's best interests and necessary to prevent harm.

Assessed by Best Interests Assessor.

Therefore each assessment must involve at least two people, a 'Section 12' doctor who has completed the approved DOL training, and a Best Interests Assessor.

Best Interests Assessor must be an approved mental health practitioner (AMHP), social worker, Nurse, OT or psychologist. THE BIA must have relevant skills and experience and must have completed the approved DOL BIA training.

To avoid a conflict of interests, where the Managing Authority and the Supervisory Body are the same the BIA cannot be employed by the Supervisory Body.

If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the person in a professional capacity or for remuneration, the managing authority must notify the supervisory body when it submits the application for authorisation (either for standard or urgent authorisation). The supervisory body must then instruct an IMCA to represent the person.

Managing Authorities.

The onus is on the managing authority to request such authorisation and implement the outcomes (although anyone can raise alarm on deprivation of liberty).

The managing authority must comply with the conditions attached to the authorisation.

Authorisation should only be sought if the DOL is in the person's best interests and protects them from harm. It is not necessary to apply for authorisation to restrict someone's liberty (in their best interests) or if the person lacks capacity to be admitted or not, or to consent or refuse treatment.

The specific local implementation for the Deprivation of Liberty safeguards is covered in a separate DOLS policy and procedure.

Deprivation of Liberty Safeguards Code of Practice.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

32 Mental Capacity and Protection of Vulnerable Adults Protection.

The Mental Capacity Act introduces the Criminal Offence of Ill Treatment and Wilful Neglect. The offence could be committed by someone who:

- Has the care of a person who lacks, or whom they reasonably believes to lack, capacity, or
- Holds enduring or lasting power of attorney for the person or

- Is a deputy appointed by the court.

Therefore, the offence can be triggered if the person lacks capacity and accused was unaware, or if the accused has a reasonable belief that the person lacks capacity and this turns out to be incorrect (i.e. the offence could still occur if the person has capacity).

Ill treatment

Ill treatment, following S127 of the Mental Health Act 1983, is regarded as:

- Deliberate conduct which could be described as ill treatment irrespective of whether this damaged or threatened to damage the health of the victim

And

- A guilty mind involving either an appreciation at that time that the accused was inexcusably ill-treating a patient or was so reckless as to whether she was inexcusably acting in that way.

Actual injury or unnecessary suffering is not pivotal to whether or not an offence did occur.

Neglect

Neglect must be shown to be wilful. This suggests a level of knowledge and a choice not to intervene. Failure to take care of a person who lacks capacity when there is a legal obligation to do so could be neglect. This would also apply to an attorney and a deputy.

MCA principles and Adult Protection

An offence could be committed if a care and treatment decision is taken in a manner that is inconsistent with the MCA. For example, an offence could be committed if a decision is made on an assumption of incapacity without a relevant assessment, or without providing reasonable support to the person to make to the decision.

Also, an offence may be committed by neglecting to take action on behalf of a person who lacks capacity.

A carer who does not initiate any proceedings into concerns that a person is being abused because they believe that the person has made an “unwise” decision to stay in a situation of abuse may be guilty of neglect.

It may be that the person is indeed living within an ‘unwise’ life choice: this should only be the considered result of an enquiry into the situation and not a reason to neglect to begin the proceedings in the first place.

Anyone under the Code of Practice is obliged to act according to the Code of Practice. Therefore any decision made on behalf of a person who lacks the capacity to make it, must be in that person’s best interests. This means that the decision must be consistent with the ‘Best Interests’ checklist set out in Section 4 of the Act and Chapter 5 of the code of practice.

Any decision which can be regarded as inconsistent with the best interests check list may not be lawful under the MCA and the decision maker would lose the protection from prosecution. This applies to anyone who holds the legal authority to make decisions, including an attorney and a court appointed deputy.

The office of the Public Guardian can investigate and revoke power of attorney.

Adult protection and the IMCA service

When a protection of vulnerable adults process involves someone who lacks capacity (either as the victim or alleged abuser), a referral can be made to the IMCA service.

Staff are required to work according to the Cambridgeshire Policy '**Protection of Vulnerable Adults from Abuse/Safeguarding Adults, Practice Guidance and Procedures, March 2008**'

33 Confidentiality, disclosure and consultation

Health and social care staff are expected to work within the five principles of the MCA to support and maximise a person's capacity to consent to disclose information.

Staff may disclose information about someone who lacks capacity to consent to the disclosure, providing that the disclosure is in the person's best interests or when there are other lawful reasons to do so. The disclosure must also follow the local policy and procedures in confidentiality and information sharing.

There is no requirement to disclose the capacity assessment to family members or carers. The capacity assessment would come under the procedure for confidentiality of personal social services records:

<http://camweb2.ccc.cambridgeshire.gov.uk/Document%20Library/OECS/ASS/AdultClient/general52.doc>

Unless there are complex or contentious issues regarding the disclosure, the assessment of capacity to consent to the disclosure does not necessarily require the completion of SOC1708. However a record must be made of the assessment and the best interests considerations, including the attempts made to support and involve the person.

A person with Lasting Powers of Attorney, or a court appointed deputy can ask to see information concerning the person providing that the information is relevant to a decision for which the attorney or the deputy has authority.

A Court of Protection visitor is allowed to examine and take copies of all relevant health, local authority social service record or care records.

A person who lacks capacity to make a particular decision may retain the capacity to consent to the disclosure of information.

34 Glossary of terms

Advance Decision to Refuse Treatment	A decision made to refuse specified medical treatment in advance of the time when a person may lack capacity to refuse. Specific regulations apply to advance decisions to refuse life sustaining treatment (Mental Capacity Act Code of Practice Chapter 9)
Advance Statement	A person may request preferences for their treatment and care. Such requests should be taken as strong indications of a person’s wishes though they are not legally binding
Adult Protection Procedures	Procedures devised by local authorities along with other relevant agencies, to investigate allegations of abuse or ill treatment of vulnerable adults. Section 44 of the Mental Capacity Act 2005 introduces the Criminal Offence of Ill Treatment or Neglect.
Appointee	Someone appointed under Social Security Regulations to claim and collect social security benefits or pensions on behalf of a person who lacks the capacity to manage their own benefits.
Attorney	Someone appointed under either Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA) to have the legal authority to make decisions within the scope of the arrangement on behalf on the person (donor) who lacks capacity.
Best Interests	Any Decision made, or anything done for a person who lacks capacity to make specific decisions must be in a person’s best interests. There are standard minimum steps that must be followed when working out someone’s best interests. These are set out in section 4 of the Mental Capacity Act.
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the Mental Capacity Act.
Court of Protection	The specialist Court for all issues relating to people who lack capacity to make specific decisions. The Court of Protection has the same powers and authority as the High Court and it is therefore able to set precedents in relation to mental capacity.

Court of Protection Visitor	Appointed to report to the Court of Protection on how attorneys or deputies are carrying out their duties.
Decision Maker	In the Code of Practice, a person making a decision on behalf of someone who lacks the capacity to make the decision themselves, is referred to as the 'decision maker'. It is the Decision Maker's responsibility to work out what would be in the best interests of the person who lacks capacity.
Deputy	Someone appointed by the Court of Protection with ongoing authority as prescribed by the Court to make decisions on behalf of a person who lacks capacity to make particular decisions as set out in Section 16(2) of the Mental Capacity Act.
Enduring Power of Attorney	A Power of Attorney created under the Enduring Powers of Attorney Act 1985 appointing an attorney to deal with the Donor's property and affairs. Existing EPAs will continue to operate under the MCA. A person does not have to lack capacity for the attorney to make decisions on their behalf.
Independent Mental Capacity Advocate (IMCA) Service	A service to help particularly vulnerable people who lack capacity to make important decisions about serious medical treatment or changes in accommodation and who have no one else appropriate to consult about these decisions.
Lasting Powers of Attorney	A Power of Attorney created under the Mental Capacity Act (Section 9(1)) appointing an attorney to make decisions about the Donor's personal welfare (including healthcare) or deal with the Donor's property and affairs.
Office of the Public Guardian	The Public Guardian is an officer established under section 57 of the Mental Capacity Act. The Public Guardian is supported by the Office of the Public Guardian, which will supervise Deputies, keep a register of Deputies, LPAs and EPAs, and investigate any complaints about Attorneys or Deputies. The OPG replaces the Public Guardianship Office (PGO) that has been in existence for many years.
Personal Welfare	Personal welfare decisions are any decisions about a person's healthcare, where they live, what clothes they

	wear, what they eat and anything needed for their general care and well-being. Attorneys and Deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity. Many acts of care are to do with personal welfare.
Property and affairs	Any possessions owned by a person (such as house or flat, jewellery or other possessions), the money that have in income, savings or investments and any expenditure. Attorneys and deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity.
Receiver	Someone appointed by the former Court of Protection to manage the property and affairs of a person lacking the capacity to do so. Existing receivers continue as deputies with legal authority to deal with the person's property and affairs.
Restraint	The use or threat of force to help do an act that 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.
Statement of Preferred Place of Care	A patient held care plan for people with life limiting illness who wish to have their choices and preferences recorded in relation to their care and ultimate place of death. A Statement of Preferred Place of Care should be taken as an indication of a person's requests. While not legally binding, every effort should be made to follow it.
Two Stage test	Using sections 2 and 3 of the Act to assess whether or not a person has the capacity to make a particular decision for themselves at time the decision is required.

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