Lancashire and South Cumbria Integrated Care Board

MENTAL CAPACITY ACT POLICY

Ref:	LSCICB_Qual01
Version:	V 1.0
Purpose	This policy sets out the roles and responsibilities of the Integrated Care Board in respect of the Mental Capacity Act 2005 and the accompanying MCA Code of Practice. This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
Supersedes:	V 2.0 of the Lancashire and South Cumbria CCGs
Author (inc Job Title):	Policy Review Group Designated Safeguarding professionals network
Ratified by: (Name of responsible Committee)	Quality Committee
Cross reference to other Policies/Guidance	NHS LSC ICB Safeguarding Children and Adults Policy incorporating standards for safeguarding and MCA for the ICB and Commissioned services. Legislative directives listed at 1.1 Scope
Date Ratified:	18 January 2023
Date Published and where (Intranet or Website):	January 2023 (Website)
Review date:	1 January 2025 (or sooner pending LPS implementation date)
Target audience:	All LSC ICB Staff

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Document control:		
Version Date:	**Version Number:**	**Changes Made:**
April 2020	V2.0	Policy reviewed by Deputy, Designated Professional for Safeguarding Adults and MCA - Central and West Lancashire CCGs
October 2022	V1.0	Revision of policy to incorporate the LSC Integrated Care Board arrangements and to be incorporated within contract arrangements with all commissioned services with consultation from: • ICB Safeguarding Policy Review Group • Lancashire and South Cumbria Designated Professionals Network • Director of Safeguarding

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1.0 Introductory

The Lancashire and South Cumbria Integrated Care Board (ICB) is required to take account of the principles within the Mental Capacity Act (2005) (MCA) and to ensure all services from whom it commissions services (both public, independent and voluntary and faith sectors) have a comprehensive policy relating to the MCA (2005) and if appropriate the Deprivation of Liberty Safeguards [1](DoLS) (2009). The function of this policy is to detail the roles and responsibilities of the ICB as a commissioning organisation and that of its employees and GP member practices. The MCA came into force in 2007 and provides a legal framework for the care, treatment and support of people aged 16 years and over, in England and Wales, who are unable to make some or all decisions for themselves. Anyone supporting people who lack mental capacity must have regard to the MCA. The MCA is accompanied by a statutory Code of Practice that explains how the MCA will works on a day-to-day basis and provides guidance to all those working with, or caring for, people who lack mental capacity.

Important note:

There is no current guidance for the new Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards, this is currently being developed nationally. This policy will be updated as soon as this has been published. Current guidelines continue until that date.

1.1 Scope

This policy applies to all staff whilst performing duties on behalf of **NHS Lancashire and South Cumbria Integrated Care Board**. This policy aims to ensure that no act or omission by the ICB as a commissioning organisation, or via the services it commissions, is in breach of the MCA or DoLS (2009) and to support staff in fulfilling their obligations. The MCA sets out who can and how to make decisions relating to care and treatment for those who lack capacity to make such decisions. The Act covers decisions relating to finance, social care, medical care and treatments, research and everyday living decisions, as well as planning for the future. The policy applies to the ICB as a commissioning organisation and its GP member practices.

Relevant legislation includes, but is not limited to:

- The Mental Capacity Act 2005 (Amended 2007 and 2019)
- The Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- The Mental Health Act (2003)
- The Human Rights Act (1998)
- The European Convention on Human Rights

1.2 Principles

The presumption of capacity should be the underpinning ethos of the interactions between health, social care and public sector workers whenever they are required to interact and/or build relationships with any member of the public. Individuals can

[1] The Liberty Protection Safeguards became law on 16th May 2019 when the Mental Capacity (Amendment) Act 2019 received Royal ascent. It is expected to replace The Deprivation of Liberty of Safeguards.

make their own decisions unless they lack the capacity to do so, which must be proved by the person who is seeking to make the decision on the person's behalf. Capacity should only be assessed if there is a reason to doubt that the person is able to take a particular decision at a specific time; it does not relate to a particular diagnostic label.

In developing this policy, the ICB recognises that implementation of the MCA is a shared responsibility with the need for effective joint working between agencies and professionals. To achieve effective joint working, there must be constructive relationships at all levels, promoted and supported by the commitment of the chief executive officer, executive safeguarding leads, senior managers and board members to:

- Implement the MCA across their organisation
- Have clear lines of accountability within the organisation for work relating to MCA
- Undertake service developments that take account of the need to incorporate the MCA Into practice and is informed where appropriate, by the views of service users
- Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in relation to implementing the MCA
- Effective interagency working, including effective information sharing

1.3 Definitions

1.3.1 Mental Capacity

Within the MCA the term capacity relates to the person's ability to make decisions for themselves including consent to or refuse care or treatment. The Act provides a two-stage test for assessing a person's capacity and this must be used for each individual decision to be made and guided by the key principles of the MCA.

Five key principles when assessing capacity

- Every adult must be assumed to have capacity unless it is proven otherwise
- All reasonable steps must be taken to assist the person to make a decision
- Individuals have the right to make unwise decisions, even those others may consider eccentric
- All actions on behalf of those who lack capacity must be in their 'best interests'
- Any treatment should be done in the least restrictive manner of the persons basic rights and freedoms

Two stage test

- Is there an impairment or disturbance in the functioning of the mind or brain?
- Does this impairment or disturbance affect the decision-making ability at the time a decision needs to be made?

Once the diagnostic test establishes that a person lacks capacity, a 4-stage functional test is undertaken to assess a person's ability to make the decision for themselves.

It is more likely than not that a person will be unable to make a decision if they cannot do one or more of the following stages:

I. Understand the information about the decision (ensuring this is provided in the most accessible way relevant to that individual)
II. Retain that information in their mind (this does not have to be for a long period of time)
III. Use or weigh that information as part of the decision-making process
IV. Communicate their decision (by talking, sign language, writing or any other means)

The burden of proof is on the assessor / decision maker to provide evidence that the person does not meet any of the functions above; and to prove that, on the balance of probability, the person lacks mental capacity to make the decision at the time it needs to be made. At times individuals may struggle to make decisions because of several factors unrelated to any impairment or disturbance that they may or may not suffer. These factors can be due to:

- Pressure, coercion, duress (Serious Crime Act 2015, Domestic Abuse Act 2021)
- Lack of sufficient information
- Information is not provided in an accessible format

In this situation, assessors / decision makers should ensure adjustments and support is offered to ensure that the person is enabled to make their own decision. On occasions a person may refuse to engage in an assessment of their mental capacity to make a specific decision. When this occurs, all efforts should be made to establish a rapport with the person to seek their engagement, and to explain the consequences of not making the relevant decision. Where this occurs, the person concerned must be informed that the professional will determine their ability to make a specific decision on the balance of probability, considering the information they already have about the person, their cognitive ability, diagnosis, and presentation.

1.3.2 Best Interests

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision 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. The Act does not define the term "best interest"; however, section 4 of the Act (supported by the Code of Practice) sets down how to decide what is in the best interests of a person who lacks capacity in any particular situation.

1.3.3 Lasting Power of Attorney (LPA)

The MCA allows a person aged 18 and over, who has capacity to make this decision, to appoint attorneys to act on their behalf should they lose mental capacity in the future. The provision replaces the previous Enduring Power of Attorney (EPA)

Lasting power of attorney (LPA) is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make

decisions on their behalf. This gives them more control over what happens to them if they have an accident or an illness and can't make their own decisions (they 'lack mental capacity'). A person must be 18 or over and have mental capacity (the ability to make their own decisions) when they make their LPA. A person doesn't need to live in the UK or be a British citizen.

There are 2 types of LPA:

- Health and welfare
- Property and financial affairs

A person can choose to make one type or both types.

1.3.4 Court Appointed Deputies

The MCA provides for a system of court appointed deputies to replace the previous system of receivership in the court of protection. Deputies can make decisions on welfare, healthcare, and financial matters as authorised by the court of protection. They are not able to refuse consent to life sustaining treatment.

1.3.5 Court of Protection

The Court of Protection has jurisdiction relating to the whole MCA and is the final arbiter for capacity matters. It has its own procedures and nominated judges. The MCA provides for a COP to make decisions in relation to the property, affairs, healthcare, and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges, and authority in relation to mental capacity matters as the High Court. It is a superior court of record and can set precedents (i.e., set examples to follow in future cases). The Court of Protection has the Powers to:

- Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions
- Appoint deputies to make decisions for people lacking capacity to make those decisions
- Decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid; and remove deputies or attorneys who fail to carry out their duties and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid

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

There may be situations where it is necessary for the ICB to cooperate with or make an application to the court of protection. This will usually be where the ICB is funding care or treatment.

1.3.6 Advance Decision to Refuse Treatment (ADRT)

The MCA creates ways for people 18 and over, and able to decide in advance to refuse treatment if they should lack capacity in the future. An advance decision to refuse treatment that is not life sustaining does not need to be in writing but the person must ensure the relevant professionals know what treatment is being refused. A decision refusing advance life sustaining treatment must be in writing, signed and witnessed with a clear statement of which treatments are being refused.

1.3.7 Independent Mental Capacity Advocate (IMCA)

An IMCA is an advocate appointed by the local authority or NHS body, in certain circumstances, to support a person who lacks capacity in the decision-making process. The decision maker must consider the views of the IMCA but is not bound by them.

1.3.8 Mental Capacity and Young People

The Mental Capacity Act applies to people aged 16 and over who may lack capacity to make a specific decision (for more information see chapter 12 MCA Code of Practice). However, the legislative framework for those cared for **under** The Children's Act (1989) will continue to apply until they are discharged from such care proceedings.

There are two elements of the Act than can be applied to young people **under** the age of 16

- Decisions about property or finance made by the Court of Protection
- Offences of ill treatment and wilful neglect

For young people aged 16 and 17 the capacity assessment must be used to determine whether the healthcare decision should be subject to the processes and provisions outlined within the Act. Depending upon the decision to be taken staff may then use the Children Act 1989 or the Mental Capacity Act to proceed with making a decision for the young person lacking capacity.

Where staff can demonstrate that they have acted in accordance with the Mental Capacity Act their actions will be protected from liability whether or not a person with parental responsibility consents. A young person's views on whether their parents should be consulted during the best interests' process should be considered.

Where staff choose to proceed with consent from someone with parental responsibility, they must inform the parent that they are required to act in the young person's best interests as outlined within the Act.

For those services working with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families in becoming familiar with the powers and provisions within the Act is an essential part of transition work. Families may choose to approach the Court to become a Court Appointed Deputy for welfare decisions or property and finance decisions. Information should be provided to assist with such applications.

There is an expectation that services providing services for 16- and 17-years olds commence transition into adult services and MCA consideration / awareness with families and the child when the child is 14 years old. The Mental Capacity Amendment Act (2019) will replace DoLS with the Liberty Protection Safeguards. When the new LPS system to come into force, the safeguards will apply to those aged 16 or over, instead of 18 and over.

2.0 Roles and Responsibilities for implementation of the MCA

2.1 General Roles and Responsibilities of the ICB

1. Establish clear lines of accountability for implementation of the MCA, which is reflected in governance arrangements
2. Secure the expertise of a lead for the MCA to support policy and training development
3. Ensure that the MCA is embedded into practice, and this is discharged effectively across the health economy through the ICB commissioning arrangements
4. Ensure that the ICB exercises a responsibility in ensuring service users receive treatment within the guidelines of the MCA Code of Practice
5. Ensure that MCA is identified as a key priority area in all strategic planning processes
6. Ensure that MCA implementation is integral to clinical governance and audit arrangements
7. The ICB oversee through governance arrangements that hospitals as managing authorities comply with DoLS legislation
8. Ensure that all health providers commissioned by the ICB have comprehensive policies and procedures for MCA implementation and Deprivation of Liberty Safeguards, and are easily accessible to staff at all levels
9. Ensure that all employees of the ICB have MCA training and competency appropriate to their role and responsibilities
10. Work in partnership with all health providers and GP member practices in achieving MCA training and competency appropriate to their role and responsibilities
11. Ensure that all contracts for the delivery of health care include clear standards for implementing the MCA; these standards are monitored thereby providing assurance that the MCA is being correctly implemented
12. Ensure that all health organisations with whom the ICB has commissioning arrangements have links with the local Mental Capacity networks and the work of the Local Safeguarding Adults Board MCA subgroup
13. Ensure that any system and process that includes decision making around individual patient activity (e.g., funding panel) clearly demonstrates compliance with the MCA. This includes ensuring that assessment of capacity is documented relating to the specific decision and any following decision is documented in line with the best interest process
14. Ensure the ICB is prepared for the Liberty Protection Safeguards implementation

15. Ensure all health organisations with whom the ICB has commissioning arrangements have strategies in place to prepare for the Liberty Protection Safeguards

2.1.1 ICB Safeguarding Director with Responsibility for MCA

1. Ensure that all service plans / specifications / contracts / invitations to tender etc. include reference to the MCA and MCA Deprivation of Liberty safeguards. Further guidance on standards is detailed in the ICB Safeguarding Accountability and Assurance Framework 2022 (SAAF)
2. Ensures that MCA is identified as a key priority area in all strategic planning processes
3. Ensures that MCA is integral to clinical governance and audit arrangements
4. Ensures the ICB co-operates with the local CSAP and LSAB in relation to MCA
5. Ensures that any system and processes that include decision making about an individual patient (e.g. funding panels) takes account of the requirements of the MCA this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act

2.1.2 ICB Individual Staff Members including GP Member Practices

1. To be aware of patient groups who may require assessment under the MCA due to an impairment or disturbance of the mind or brain. Any treatment decisions that follow an assessment of capacity must be fully documented to ensure the best interest process has been followed
2. According to role, undertake training (as appropriate), including attending regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the MCA
3. Understand the principles of confidentiality and information sharing in line with the MCA
4. All staff contribute, when requested to do so, to the multi-agency best interests' meetings when related to funding of placements / care and treatment decisions

3.0 Implementation

3.1 Method of Monitoring Compliance

Healthcare providers will be required to complete the self-assessment Safeguarding Assurance Audit Framework which includes standards for MCA. As part of the monitoring of safeguarding arrangements for commissioned services, safeguarding standards are incorporated into the annual contract process. Assurance is provided through the ICB self-assessment based on the Safeguarding Accountability and Assurance Framework 2022. Additionally, learning applied from safeguarding adult reviews are reviewed via ad hoc audits; this forms part of the assurance of sustained implementation.

3.2 Breaches of Policy

This policy is mandatory. Where it is not possible to comply with the policy or a decision is taken to depart from it, this must be notified to the ICB so that the level of

risk can be assessed, and an action plan can be formulated (see section 3.3 for contact details).

3.3 Contact Details

Local Authority Area	LSC ICB Safeguarding Team	Local Email contact
Lancashire	Central	lscicb-csr.safeguarding@nhs.net
	East	penninelancs.safeguardingteam@nhs.net
	North	lscicb-mb.qst@nhs.net
Blackpool	Fylde and Wyre	lscicb-fw.safeguarding@nhs.net
Blackburn with Darwen	Pennine	penninelancs.safeguardingteam@nhs.net
South Cumbria	Morecambe Bay	lscicb-mb.qst@nhs.net

4.0 Reference Documents

In developing this Policy, account has been taken of the following statutory guidance:

Statutory Guidance

- Department for Constitutional Affairs (2007) MCA 2005: Code of Practice. TSO: London
- Ministry of Justice (2008)
- Deprivation of Liberty Safeguards Code of Practice to Supplement MCA 2005. London TSO The stationery Office, Children's commissioner (2004) Children Act 2004, London TSO
- HM Government (2019) The Mental Capacity Amendment Act 2019
- Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework (2022)
- NICE National Institute for Health and Care Excellence: Decision-making and mental capacity overview

Care Quality Commission

- Care Quality Commission (2009) Guidance about compliance: Essential Standards of Quality and Safety

5.0 Appendices

5.1 Checklist for practitioners applying the Mental Capacity Act

Checklist for practitioners applying the Mental Capacity Act
5 Principles: Apply them in practice 1. Assume the person has capacity unless proven otherwise. 2. Enable capacity by assisting the person when making a decision (use visual aids / written words / interpreters etc. as appropriate). 3. If a person with capacity makes an unwise or eccentric decision this must be respected. 4. If a person lacks capacity treatment decisions must be made in the person's best interests (follow the statutory checklist). 5. The treatment given should be the least restrictive option to the person's rights and freedoms. Ref Code of Practice Chapter 2
Enabling Capacity: Have you, • Been clear about what decision needs to be made, define it clearly and concisely (this helps in other aspects of the Act). • Made every effort to enable the person to make the decision themselves, by being flexible and person-centred. • Provided information about the decision in a format that is likely to be understood including information relating to any alternative options. • Used a method of communication/language that the person is most likely to understand. • Made the person feel at ease and given consideration to what is likely to be the most conducive time and location for them to make the decision. • Considered if others can help the person understand information or make a choice. Ref Code of Practice Chapter 3
Assessing capacity: Does the person have an impairment or disturbance in the functioning of the mind or brain? (Temporary or permanent) If yes practitioners must complete the 4-part functional test. Can the person…. 1. understand the information relevant to the decision? 2. retain the information long enough to make a decision? 3. weigh up the consequences of making the decision? 4. communicate their decision by any means? If the person fails to demonstrate ability in any of the four areas, they would be deemed as lacking capacity to consent to or refuse that specific decision. Ref Code of Practice Chapter 4
Decision Maker: Have you, • Identified the decision maker • Identified if the person has a registered Lasting Power of Attorney (LPA) or a court appointed deputy (CAD) for personal welfare who can consent or refuse treatment. • Considered if decision can be delayed till the person regains capacity Ref Code of Practice Chapter 5; 7 and 8
IMCA: Does the person require an Independent Mental Capacity Advocate?

Ref Code of Practice Chapter 10
Deciding Best Interests: have you • Encouraged participation • Not discriminated or been driven by a desire to bring about death • Considered person's views and wishes • Promoted the person's rights • Identified if the person has an Advance Decision to Refuse Treatment (ADRT) that is valid and applicable • Identified and spoken with family friends or others to be consulted • Considered all relevant factors • Reviewed the risks and benefits of the proposed procedure and its alternatives including not providing treatment. (options appraisal) • Reviewed and weighted all the evidence considering medical social welfare emotional and ethical aspects • Arrived at a decision • Communicated your decision and rationale • Put in place steps to implement the decision that is least restrictive Ref Code of Practice Chapter 5
Restraint: Restraint is use force – or threaten to use force – to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. Does what you are proposing fall within the definition of restraint? Is the restraint necessary to prevent harm? Is the level of restraint proportionate to the likelihood and severity of harm? You cannot deprive of liberty without lawful authorisation Ref Code of Practice Chapter 6
Protection From Liability: Follow the Act; document it and you will receive protection from liability Ref Code of Practice Chapter 6

5.2 Equality and Health Inequalities Impact Risk Assessment (EHIIRA)

This policy has been reviewed 3 November 2022 in line with Equality and Health Inequalities Impact Risk Assessment requirements and approved on 8 November 2022.

A copy of the EHIIRA is available on request.