Mental Capacity Act

and

Deprivation of Liberty Safeguards Policy

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## Version Control

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1.0 Summary

The Mental Capacity Act is a pivotal piece of legislation, introduced to protect those who are unable to make decisions around their health, welfare, care and treatment and therefore all staff within the CCG should be aware of the relevance of the Act within their roles and how this applies to commissioning services and in seeking assurance.

2.0 Introduction

The purpose of this policy is to provide NHS Warrington CCG employees with guidance around their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and directs them to wider reading available at the Office of Public Guardian: www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people who cannot make decisions for themselves. The Mental Capacity Act helps organisations to protect vulnerable groups within a legal framework which is supported by a Code of Practice.

The policy sets out, how capacity should be assessed and procedures for making decisions on behalf of people who lack mental capacity. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision, or act for themselves must be made in their best interests.

Everyone working with or caring for an adult over the age of 16 who may lack capacity to make a specific decision must comply with the Mental Capacity Act, irrespective of whether the decision relates to a life changing event or an everyday matter.

This policy details the roles and responsibilities of Warrington CCG as a commissioning organisation, with respect to mental capacity issues.

Various legislation and guidance are published that is relevant to this policy which employees should be familiar with and refer to as required:

- The Care Act 2014
- The Mental Capacity Act 2005
- The Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
• The Mental Health Act 1983 (as amended 2007)
• The Human Rights Act 1998
• The European Convention on Human Rights
• The Care Standards Act 2003
• The Children Act 1989

3.0 Scope & Definitions

This policy applies to all employees of Warrington CCG, particularly those CCG Clinical Staff who work in Continuing Health Care who have responsibility for commissioning NHS Continuing Healthcare and NHS-funded Nursing Care.

This policy should be read in conjunction with Warrington’s Multi-Agency Safeguarding Policy.

The MCA Code of Practice should also be referred to as a supportive document.

4.0 Roles & Responsibilities

CCG staff

The Chief Clinical officer for Warrington CCG ensures that promoting the safeguarding of adults, (including The Mental Capacity Act), is discharged effectively across the whole local health economy through the organisations commissioning arrangements.

The Mental Capacity Act (MCA) and Deprivation of Liberty, (DOLS) lead Warrington CCG is the Designated Nurse for Safeguarding Adults. Warrington Borough (WBC) receives funding via Warrington Clinical Commissioning Group to undertake the lead agency role for assessment, approval and review of DOLS applications. The Mental Capacity Act and Governance Lead for WBC can be contacted At Warrington Council, Newtown House on the following Email address: pdavidson@warrington.gov.uk.

The Designated Nurse for Safeguarding Adults has lead responsibility for the CCG to provide the leadership; skills; expertise and ability to steer the adult safeguarding agenda and ensure compliance with the Mental Capacity Act. The Designated Nurse for adults can be contacted at WCCG Headquarters on the following Email address: julie.ryder3@nhs.net

The Designated Nurse for Children has lead responsibility for the CCG to provide the leadership; skills; expertise and capacity to safeguard children and will facilitate compliance with the Mental Capacity Act. The Designated Nurse for children can be contacted at Warrington Council, Newtown House on the following Email address pauline.owens@nhs.net
Where Warrington CCG is identified as the co-ordinating commissioner it will notify associate commissioners of a provider’s non-compliance with their responsibilities with respect to mental capacity issues, or of any serious untoward incident that relates to mental capacity issues.

**Discharging of duties**

In order to discharge its responsibilities with respect to the Mental Capacity Act Warrington CCG will:

Ensure that all staff employed by the CCG is aware of their responsibilities with respect to the MCA and ensure that staff always operate in compliance with the act and the accompanying code of practice.

Ensure that staff undertake training; including attending regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the Mental Capacity Act.

The CCG will ensure that its employees understand the principles of confidentiality and information sharing in line with the Mental Capacity Act.

Ensure all employees contribute, when requested to do so, to the multi-agency best interest meetings when related to funding of placements and ensure that training with regard to the mental capacity act and its effective implementation is provided to CCG staff.

Develop a clear line of accountability for mental capacity matters, built into internal CCG governance arrangements.

The CCG will Engage with local Safeguarding Adults Board (SAB) and be a statutory board member.

Work with local agencies to provide joint strategic leadership on MCA and DOLS in partnership with Local Authorities, provider clinical governance teams and safeguarding leads, CQC, and where applicable, the police.

Ensure that providers deliver on the NHS standard contract specifically around the compliance with MCA and DOLS legislation and that commissioned services are supported, and contract monitored for compliance with MCA (Using the National NHS England, Safeguarding Audit Tool for monitoring which is locally adapted).

Ensure that learning from cases where mental capacity has been an issue will be used to inform future commissioning and practice.

Ensure that leads for safeguarding adults and mental capacity within the CCG have broad knowledge of healthcare for older people, people with dementia, people with access support and training where learning needs are identified.
Ensure that safeguarding and MCA leads work within the local health and social care economies to influence local thinking and practice around MCA.

Ensure that best practice around mental capacity is promoted, implemented and monitored both within the CCG and within commissioned provider services.

Ensure that the principles of the MCA are embedded into policies/procedures for End of life Care decisions across the Warrington footprint.

Ensure that providers have the assessment tools, care planning and pathways in place to assess capacity and carry out best interest meetings.

Engage with patients and the public in order to seek their views and ensure that literature/information is available for them to access, which includes easy read material.

CCG Continuing Health Care Staff should provide reports into the Quality Team for the attention of the Quality Committee to provide assurance around the assessment, management and review of health funded patients in terms of their capacity to consent to care and their placement and in respect of any deprivations which may occur in regulated and none regulated establishments.

5.0 Process / Requirements

This policy will be available for all staff to access within the CCG. The policy will be found available on the CCG website. All staff should make themselves familiar with the policy and how it translates to local practice and e-learning.

6.0 Training

NHS Warrington CCG will ensure that the adult safeguarding intercollegiate document levels of training in relation to MCA is reflected in the revised mandatory training through ESR and accordingly as per national legislative changes.

7.0 Equality & Diversity

An Equality and Diversity Impact Assessment has been completed.

8.0 Review
This document will be reviewed as a result of changes made to multi-agency safeguarding procedures and to reflect any national legislative changes. A review will be undertaken every 3 years.

9.0 Monitoring / Audit

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<tr>
<th>Key Performance Indicators</th>
<th>Frequency</th>
<th>Monitoring</th>
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<tr>
<td>a) Number of MCA Assessment undertaken by the CHC Team</td>
<td>Quarterly</td>
<td>Designated Nurse for Safeguarding to report to relevant Committee’s.</td>
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<td>b) Number of applications to the Court of Protection due to Deprivation of Liberties within the own home by the CHC Team. This indicator will be amended to reflect future changes to the legislation under LPS</td>
<td>Quarterly</td>
<td>Designated Nurse for Safeguarding to report to relevant Committee’s.</td>
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<tr>
<td>c) Annual contribution to the CCG’s Safeguarding Annual Report from the Continuing Healthcare Team regarding MCA compliance</td>
<td>Annual</td>
<td>Designated Nurse for Safeguarding to report to relevant Committee’s.</td>
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10.0 Monitoring Compliance and Effectiveness

Compliance towards the MCA will be achieved by the monitoring of providers using:

- Safeguarding self-assessment audit tool.
- Review of serious Incidents
- Quarterly dashboard completion
- Monitoring visits
- The afore mentioned will be standing agenda items on the contract quality meeting agenda

Please refer to the overarching commissioning safeguarding adults and children’s policy for relevant appendices relating to auditing requirements.
This policy will be reviewed and monitored by Warrington CCG Safeguarding lead on an annual basis or sooner dependent on any changes to legislation.

11.0 Values

Warrington CCG is responsible for commissioning high quality services for patients in Warrington and has a duty and commitment to those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to illness, disability, frailty etc.

Warrington CCG is accountable for ensuring its own safeguarding adults’ structures and processes, and those in agencies from which we commission services meet the required standards. To ensure that providers are compliant with contractual agreements and The Care Quality Commissions Standards for Safeguarding, it essential that CCG’s are equipped with policies, training and process around Acts of Law which help protect those most at risk in society. Those who often present as most vulnerable being people who lack capacity to make decisions about their own care, treatment, finances and residency.

Warrington CCG has an overarching commissioning safeguarding children and adult policy which incorporates service delivery standards and should be read in conjunction with this policy.

It has been made clear through the mandate from the Government to NHS England, March 2013 that the NHS improves safeguarding practice in the NHS, reflecting also the commitment to prevent and reduce the risk of abuse and neglect of adults. Additionally, the NHS Constitution through the Health and Social Care Act 2012 provides a statutory duty to continually seek to improve the quality of care to patients and to treat individuals with dignity and respect in accordance with their Human Rights. With the introduction of the Care Act 2014, safeguarding adults gained statutory footing.

12.0 Objectives

Warrington CCG has a statutory responsibility for:

- Ensuring that the organisations from which it commissions services provide a safe system which safeguards vulnerable children and adults, including adults who lack mental capacity.
• Ensuring it commissions MCA compliant care and will ensure that providers meet their statutory responsibilities to those patients/customers who access services.
• Ensuring that all staff employed by NHS WCCG are aware of their responsibilities under the MCA and that their staff always operate in accordance with the MCA and the accompanying code of practice.

13.0 Providers / Monitoring around MCA

Provider organisations are responsible for: ensuring compliance with MCA legislation including Deprivation of liberty Safeguards (DOLS) within and across their organisation.

The Care Quality Commission (CQC) Standards for safeguarding require providers who are regulated to comply with standards around the MCA and have the evidence of organisational compliance ready for inspections that may occur in due course.

Providers must ensure that there is clarity as to who holds corporate responsibility for MCA and DS functions within the organisation, and that appropriate governance and safeguarding systems are in place to deliver best practice.

Providers must be in a position to provide assurance to CCGs that their responsibilities with respect to MCA are being safely discharged.

Providers will be audited for MCA compliance using the NHS England Safeguarding audit tool, adapted locally to meet local needs.

Providers will be expected at the request of the Designated Nurse at any time to produce reports, audits in relation to Mental Capacity Assessments, best interest documentation/minutes of meetings, and evidence of DOLS applications made and associated care plans.

14.0 Consultation Process

This policy will be shared, and consultation shall be sought within NHS Warrington CCG.

15.0 Dissemination and Implementation

This policy upon ratification via the Policy Review Group will be made available on the trust intranet site.
Following approval this document will be entered onto the corporate document database.

It is the responsibility of managers to ensure that this policy is adhered to by all staff and is explained to new staff at local induction. Failure to adhere to this policy may result in disciplinary action.

16.0 References


Church. M, Watts. S. Assessment of Mental Capacity: a flow chart guide (on line)

Royal College of Psychiatrists (17/05/13). http://pb.rcpsych.org/content/13/8/304/f1.expansion.html


NHS England (2013) an Aide Memoire for Clinical Commissioning Groups: Safeguarding Adults


The Law Society – Deprivation of Liberty; a practical guide 2015

17.0 The Mental Capacity Act (A legislative safeguard)

It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or

People may have problems making some decisions from time to time, maybe due to illness, tiredness or indecision. But the MCA is designed to go beyond these types of
situations for example, serious life-changing decisions like whether to move into a care home or have major surgery. It is designed specifically to empower and protect an individual who may be unable to make a decision because of the way their mind or brain works is affected, for example, by illness or disability, or the effects of drugs or alcohol.

Having mental capacity means that a person is able to make their own decisions.

When to assess capacity

Under the MCA, a person is required to make an assessment of capacity before carrying out any care or treatment if a practitioner has reasonable belief someone lacks capacity – the more serious the decision, the more formal the assessment of capacity needs to be. A lack of capacity cannot be decided based upon age, appearance, condition or behaviour alone.

The principles

A practitioner should always start from the assumption that the person has the capacity to make the decision in question (principle 1).

The practitioner should also be able to show that they have made every effort to encourage and support the person to make the decision themselves (principle 2).

It must also remember that if a person makes a decision which is considered eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3).

Practice Guidance

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, the practitioner will need to involve family, friends, carers or other professionals.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? The practitioner should be able to show in your records why you have come to your conclusion that capacity is either present or lacking for the decision.

A person must be assumed to have capacity unless it is established that he/she lacks capacity.
A person must not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

**The test to assess capacity**

**The two-stage functional test**

In order to decide whether an individual has the capacity to make a decision there are two questions:

**Stage 1.** Is there an impairment of, or disturbance in the functioning of a person’s mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol. If so,

**Stage 2.** Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

Any action taken or any decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests. Before any action is taken, or any decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person.

**18.0 Capacity Assessment Tips**

**Who should assess capacity?**

Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity – follow the two-stage test.

The MCA is designed to empower those in health and social care to undertake capacity assessments themselves, rather than rely on expert testing by psychiatrists or psychologists.
However, in cases involving complex or major decisions then the assessor could be a (consultant psychiatrist or psychologist).

What and when to record will vary. As a general rule, there is no need to record assessments of capacity around day-to-day decisions. In order to have protection from liability when providing care or treatment, carer’s must have a reasonable belief that the person they care for lacks capacity to make relevant decisions about their care or treatment.

In these circumstances, it is useful to be able to describe the steps taken and have a written record.

Professionals are subject to higher standards in terms of record keeping and a formal record will be required to be kept, for example in the patient’s clinical notes if a doctor or a healthcare professional is proposing treatment for someone who lacks capacity. (The assessment tool can be located in the appendices to the rear of the policy).

19.0 Best Interest Check List / Documentation

Best Interest Checklist:

Consider:

- All the relevant circumstances.
- A delay until the person regains capacity.
- Involving the person in the decision making as much as possible. Even though it has been determined that the individual lacks capacity to make this decision, their views need to be considered and the process needs to include them as far as possible.
- The person’s past and present wishes, beliefs and values that would influence their decision making if they had capacity and other factors the person would take into consideration if making their own decision.
- Any advance statements made.
- The beliefs and values of the individual.
- Considering views of family and informal carers. Considering views of Independent Mental Capacity Advocate (IMCA) or other key people.
- Showing it is the least restrictive alternative or intervention.
- The decision must not be made merely on the basis of the person’s age or appearance.
- The person’s behaviour should not lead to assumptions about what might be in their best interests.
- If the person likely to regain capacity? Can the decision wait?
- If the decision concerns life sustaining treatment, the decision must not be based on a desire to bring about death. This states that the MCA cannot be used for the purposes of euthanasia.
- Taking into account the views of anyone caring for the person or interested in their welfare – this includes paid and informal carers. The decision maker
must consult if possible anyone who has a Lasting Power of Attorney or is a deputy appointed by the Court of Protection.

20.0 Using the Best Interest Checklist:

- The decision maker is responsible for the decision.
- The decision maker must consult and involve others as much as possible.
- The decision maker does not have to follow the views of anyone else, but would need a good, reasoned argument for ignoring the views of others.
- Do not avoid discussion with people who may disagree with the decision maker. Involving people who might disagree with the decision in the process can often reassure them of how the decision is being made and can allow them to accept the final decision.
- There is no prescribed method of consultation. The decision maker could see family members together with the person being assessed if appropriate, but this may not be helpful.
- There is no hierarchy of whose views within a family should carry more weight. The concept of ‘next of kin’ does not mean anything under MCA.
- A best interest decision needs to consider a holistic assessment of the individual. For instance, what would be clinically indicated may not be in someone’s best interests when their past views are considered, or the possible effects of the treatment are considered. If a move from one care home to a different one is being considered it could be that someone’s needs might be better met in a different setting but consider as well the effects of the stress of a move or the distance from family contact.
- Under the Deprivation of Liberty Safeguards there is a specialist role for experienced staff who receives extra training of: ‘Best Interests Assessor’. This role only relates to decisions taken under DOLS and does not apply to best interests’ decisions made under MCA.

21.0 Best Interest

How to formalise a best interest decision

- A best interest decision can be made and recorded by the decision maker
- It is often not necessary to hold a Best Interests Meeting to formalise the decision making.
- It is always necessary to record the best interest’s decision.
- If you are using the MCA capacity assessment form the best interest’s decision should be recorded on this form. It can otherwise be recorded within a care plan or within notes. (The best interest tool forms part of the capacity assessment tool, provided in the appendices)

22.0 Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA).
IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

The IMCA role is to support and represent the person in the decision-making process. Essentially, they make sure that the Mental Capacity Act 2005 is being followed.

The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 set out the IMCA’s role and functions. These are grouped below into four areas:

(i) Gathering information
- Meet and interview the person (in private if possible).
- Examine relevant health and social care records.
- Get the views of professionals and paid workers.
- Get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person.
- Find out other information which may be relevant to the decision.

(ii) Evaluating information
- Check that the person has been supported to be involved in the decision.
- Try to work out what the person’s wishes and feelings would be if they had capacity to make the decision and what values and beliefs would influence this.
- Make sure that different options have been considered.
- Decide whether to ask for a second medical opinion where it is a serious medical treatment decision.

(iii) Making representations
- IMCAs should raise any issues and concerns with the decision maker. This could be done verbally or in writing. IMCAs are required to produce a report for the person who instructed them. In most cases this should be provided to the decision maker before the decision is made.
- People who instruct IMCAs must pay attention to any issues raised by the IMCA in making their decision

(iv) Challenging decisions
- In many cases IMCAs will be able to resolve any concerns they have with the decision maker before the decision is made. Where this has not been possible IMCAs may formally challenge the decision-making process. They can use local complaint procedures or try to get the matter looked at by the Court of Protection.
How to contact the IMCA Service Tel: 01925 246 938 / 01925 248 472

For referrals to Warrington Speak Up Advocacy Hub:

Telephone: 01925 246 888
referral@advocacyhub.org.uk
info@advocacyhub.org.uk
The Gateway
89 Sankey Street
Warrington
WA1 1SR

Warrington Speak Up can be contacted when there are serious medical decision’s needing to be discussed, a change of accommodation, Adult Safeguarding Procedures, Care Review or Deprivation of Liberty safeguards. If CCG employees are face with difficulties in obtaining IMCA support the issues should be put into writing and shared with the CCG safeguarding Lead so that this can be flagged with the relevant commissioners

23.0 Mental Capacity Act Deprivation of Liberty Safeguards

Defining Deprivation of Liberty

The Deprivation of Liberty Safeguards (DOLS) are an addition to the MCA, introduced to provide a statutory framework for the Deprivation of Liberty of people in registered establishments, care homes or hospitals, specifically to prevent breaches of the European Convention on Human Rights 1998 (ECHR) and to prevent authorities taking arbitrary decisions on this matter.

The Deprivation of Liberty Safeguards apply when the care or treatment of an individual without capacity, residing in hospital or a care home, can only be delivered in circumstances which represent more than restriction of their liberty but instead amounts to a deprivation of their liberty.

24.0 DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) and the Judgement of the Supreme Court

P v Cheshire West and Chester Council and another P and Q v Surrey County Council.

The above ruling resulted in changes to how DOLs are assessed and authorised.

The following question should be asked:
- Is the person objectively deprived of their liberty or is there a risk that cannot be sensibly ignored that they are objectively deprived of their liberty?
There are two key questions to ask – the ‘acid test’:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

All of these factors are necessary. You should seek legal advice if intensive levels of support are being provided to any person as part of a package of care or treatment.

The focus is not on the person’s ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave.

NB: for a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave.

In all cases, the following are not relevant to the application of the test:

- The person’s compliance or lack of objection;
- The relative normality of the placement (whatever the comparison made); and
- The reason or purpose behind a particular placement.

This document is based upon the law as it stands as at March 2014; it is intended as a guide to good practice and is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon this document.

DOLS regime cannot be used for a child under 18.

A DOLS authorisation cannot be used to authorise a deprivation of liberty taking place in a children’s home.

The Court of Protection can authorise the deprivation of a person’s liberty from the age of 16.

The DOLS process for obtaining a standard authorisation or urgent authorisation can be used where individuals lacking capacity are deprived of their liberty in a hospital or care home.

The Court of Protection can also make an order authorising a deprivation of liberty.

This is the only route available for authorising deprivation of liberty in domestic settings such as the adult’s own home and supported living arrangements.

For Further information please see The Law Society web site – Deprivation of Liberty: a practical guide 9th April 2015

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/
Amendments around the Liberty Protection Safeguards system proposed by the Law Commission and pledged to legislate when parliamentary time allows were announced in 2017. Since this announcement the government has given Royal Accent on the 16th May 2019 to what is now the Mental Capacity (Amendment) Act 2019, although no details have yet been given as to when the Liberty Protection Safeguards (LPS) scheme will be brought into force. Rather than the Local Authority being responsible for assessments this would fall to an approved Mental Capacity professional. This would mean that hospitals would be able to authorise deprivations of liberty for patients placed there and the CCG would be responsible for the assessment and authorisation of their health funded patient’s under LPS

25.0 Who Deprivation of Liberty Safeguards Applies to

Deprivation of Liberty safeguards protect people who are 18 years and over who lack capacity to make decisions about treatment or care and who need after all other avenues have been explored to be cared for in a restrictive way. For example, some people who have dementia, a mental health problem (not detained under the Mental Health Act 2007) or a significant learning disability. The aim of the safeguards is to:

- Ensure people are given the care they need in the least restrictive way,
- Prevent decisions being made to suit the home or hospital rather than the needs of the adult at risk
- Provide safeguards for adults at risk
- Provide the rights to challenge unlawful detention against the person's will.

Where the Deprivation of Liberty Safeguards is applied in a hospital setting, the supervisory body is the Local authority, who since April 1st 2013 became the only Supervisory Body for the Deprivation of Liberty outside the Court of Protection. Hospitals will be required apply to local authority Supervisory Bodies where they think they may need to deprive a patient of their liberty to treat them.

Applications can be made on either an ‘urgent’ or ‘standard’ basis.

An urgent application involves the managing authority (hospital or care home) actually granting itself an authorisation to deprive an individual of their liberty for a period of 7 days whilst the supervisory body considers the application. This period can be extended for a period of 7 days in exceptional circumstances.
A standard authorisation can be applied for up to 28 days in advance of when the managing authority wishes to plan to deprive the person of their liberty. Examples of this practice are around planned acute hospital admissions which require specific restrictions to be in place and which have been agreed following the MCA process.

Authorisation forms for urgent or standard DOLs can be downloaded from the Warrington Council web site

Hospitals remain responsible as managing authorities, for compliance with the DOLS legislation, for understanding the DOLS and knowing when and how to make referrals. Hospitals also remain responsible for ensuring that all care and treatment in hospitals is Mental Capacity Act (MCA) compliant.

Those staff employed by the WCCG who visit, assess, treat, monitor and review patients residing in registered care establishments and or residing in hospitals should be aware of the Deprivation of Liberty Safeguards and their remit within this. Those staff responsible for commissioning and contracting should be aware of the importance of the Act and adherence towards this from commissioned providers

If staff are visiting a care home or hospital where they think a person is being deprived of their liberty, they should see if care could be provided in a less restrictive way. If depriving the person of their liberty seems unavoidable, it is advised that an application should be made for a standard authorisation at the same time as an urgent authorisation is given.

If someone in another setting is possibly being deprived of their liberty this should bring this to the attention of the manager so they either change their care or seek authorisation. Other options are to inform the supervisory body, to make a safeguarding alert to the local authority, or to challenge what may be an unlawful deprivation of liberty in the Court of Protection.

NHS Warrington CCG employees should report any concerns of non-compliance with the MCA/DOLS back through their organisation’s governance structures.

This policy therefore does not seek to give detailed guidance on the matter, but instead signposts staff to the DOLS code of practice, to the literature produced by the Department of Health, and to the body of decisions made by the court of protection.

For further information employees should refer to the DOLS Code of Practice. The relevant authorisation forms can be found and downloaded via the Warrington Council web site.
Appendix 1 – Mental Capacity Assessment

For use by WCCG employees - To be completed by the person proposing the treatment

Patients Name………………………………………………………………………………………………………..
DoB……………………………………………………………………………………………………………………..
NHS Number………………………………………………………………………………………………………..
Date of assessment…………………………………………………………………………………………………..

What is the decision to be made/issue

………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………

Is there are least restrictive alternative?

………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………

In order to decide whether an individual has the capacity to make a particular decision they must answer two questions:
Assessment questions

Q1

Stage 1: Is there an impairment of, or disturbance in the functioning of a person's mind or brain? If so,

Stage 2: Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

Yes / No

Evidence…………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
If Yes to question one then proceed to Q2
If No the person is deemed to have capacity

Q2

A) With help is the person able to understand the relevant information- the decision, consequences

Yes / No

Evidence…………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
If the answer to any of Q2 (A to D) is NO then the person lacks capacity

When making the assessment of capacity the assessor should ensure that:

- All relevant and sufficient information has been given by the most effective method of Communication- consider advocates, input from SALT etc
- Best location has been chosen where the person feels most at ease to make the decision
- The best time of day has been chosen to make the decision
- If the person would benefit from having another person present the arrangements have been made
- Consider if the impairment of capacity is temporary and if so can the decision wait?
- Remember people are allowed to make unwise decisions

**Evidence and Conclusion / Outcome**

Decision-maker: ………………………………………………………………………………………………………

Organisation:
…………………………………………………………………………………………………………………………

Role: …………………………………………………………………………………………………………………

Telephone Number: …………………………………………………………………………………………………

Signature: ……………………………………………………………………………………………………………

Date assessment completed: ………………………………………………………………………………………

Counter signature: …………………………………………………………………………………………………

Please refer to the best interest checklist and the need for a MDT meeting when considering if the decision to be made is in the persons best interest.
Best Interest Meeting

Mental Capacity Act (2005)

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his/her best interests-Principle 4 of the MCA

<table>
<thead>
<tr>
<th>Meeting held on:</th>
<th>Venue:</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Male / Female  Ethnicity</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>Postcode:</td>
<td></td>
</tr>
<tr>
<td>Chair of meeting</td>
<td>Decision Maker</td>
</tr>
<tr>
<td>Name of participants</td>
<td>Designation / Location</td>
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</table>


<table>
<thead>
<tr>
<th>Confirmation of ‘lack of capacity’</th>
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<tbody>
<tr>
<td>Mental Capacity Record assessment attached and completed</td>
</tr>
<tr>
<td><strong>AND</strong></td>
</tr>
<tr>
<td>Those present / invited agree that the person ‘lacks capacity’ to make the decision  (In the event of anybody challenging the assessment result, and the disagreement cannot be resolved, then a second opinion or a ruling from the Court of Protection may be required. This will depend on the urgency of the decision to be made)</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
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<tr>
<th>Regaining of Capacity (Is it likely that the person may regain capacity, can the decision wait until that time, if not why not?)</th>
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<tr>
<td>Is this the least restrictive option?  (If not, why not?)</td>
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<th>Justification for proposed care / treatment:</th>
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<th>Risks relating to proposed care / treatment:</th>
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<td>Risks related to not carrying out the proposed care / treatment:</td>
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<tr>
<td>Question</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>What are the persons past and present wishes and feeling (These may have been expressed verbally, in writing or through behaviour or habits)</td>
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<tr>
<td>Are there any beliefs and or values that would be likely to influence the decision, if he/she had the capacity? (e.g. religious, cultural, moral or political)</td>
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<tr>
<td>What are the views of the other relevant people in the person’s life?</td>
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<tr>
<td>What are the views of the Mental Capacity Advocate (IMCA)? (If involved)</td>
</tr>
<tr>
<td>Is there a dispute about best interests?</td>
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</table>
Outcome of discussions; reasonable belief as to best interests-

Where the court is not involved, carers (unpaid), relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances.

The undersigned believe this to be a fair and accurate representation of the discussions that took place. Those in attendance have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

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### Appendix 2 – Consent to Screening and Assessment for NHS Continuing Healthcare / Funded Nursing Care

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<tr>
<th>Patients name:</th>
<th>NHS No:</th>
</tr>
</thead>
</table>

*Under the terms of the 2005 Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity.*

### 1A) Person has capacity - If a person has capacity, only they can consent:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>I have received</strong> verbal / written information on the Continuing Healthcare assessment process and I am aware that I can withdraw consent at any time.</td>
<td></td>
</tr>
<tr>
<td><strong>Date consent withdrawn:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>I have</strong> been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy, and that I have the right to decline any subsequent offer of care.</td>
<td></td>
</tr>
<tr>
<td><strong>I consent</strong> to an NHS Continuing Healthcare Checklist / Fast Track / Decision Support Tool and any subsequent reviews being undertaken.</td>
<td></td>
</tr>
<tr>
<td><strong>I consent</strong> to relevant information being gathered, collated and shared, where necessary and relevant, both as part of the CCG NHS Continuing Care process and as part of any subsequent dispute, including Independent Review Panel and Parliamentary and Health Service Ombudsman (PHSO).</td>
<td></td>
</tr>
<tr>
<td>I have been informed that NHS Continuing Healthcare eligibility, including Fast Track, is subject to on-going review and is not indefinite.</td>
<td></td>
</tr>
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</table>

### I would like the following person / representative involved in the assessment:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Patient:</td>
<td>Contact Number:</td>
</tr>
<tr>
<td>Print Name:</td>
<td></td>
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</tbody>
</table>

### 1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Name:</th>
<th>Designation / relationship:</th>
<th>Date:</th>
</tr>
</thead>
</table>
### 1C) Person has capacity - Consent to share and protect your personal information

<table>
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<tr>
<th>I agree</th>
<th>that the information provided in this assessment may be shared with health and social care staff, service providers or brokers who contribute to or provide my care and any agencies acting on behalf of these organisations for the purpose / process relating to NHS Continuing Healthcare.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand</td>
<td>that this information will be used in the assessment of my eligibility for NHS continuing healthcare funding and may be used and shared with providers of care and brokers for commissioning and or providing or a service, or care to me.</td>
</tr>
<tr>
<td>I understand</td>
<td>that I may withdraw my consent to share information at any time.</td>
</tr>
<tr>
<td>I understand</td>
<td>that I have the right to restrict what information may be shared and with whom but that this may affect the provision of care to me.</td>
</tr>
<tr>
<td>I have made the following restrictions (if applicable):</td>
<td></td>
</tr>
<tr>
<td>I understand</td>
<td>that my information will be held on paper and on computer in accordance with the Data Protection Act 1998.</td>
</tr>
</tbody>
</table>

| Signature: | Date: |
| Print Name: | Date: |

### 1b) Where person has capacity but is only able to verbally consent, this must be witnessed by two people:

| Signature: | Name: | Designation / relationship: | Date: |

*If the person does not have the capacity to consent, then a ‘Best Interest’ decision will need to be made. Please proceed to complete the Best Interest part of the form.*
2) Best Interest Consent to Screening and Assessment for NHS Continuing Healthcare / Funded Nursing Care for People who lack capacity

<table>
<thead>
<tr>
<th>2A) Best Interests Checklist</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>I have made every possible attempt to permit / encourage the person to take part in the assessment process</td>
<td></td>
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<tr>
<td>I have tried to identify all the things that the person would take into account if they were making the decision or acting for themselves.</td>
<td></td>
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<tr>
<td>I have tried to find out the views of the person who lacks capacity, including past / present wishes and feelings, any beliefs and values and any other factors that the person themselves would be likely to consider if they were making the decision or acting for themselves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I confirm that I have not made assumptions about their best interests on the basis of the person’s age, appearance, condition or behaviour.</td>
<td></td>
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<tr>
<td>I have considered whether the person is likely to regain capacity.</td>
<td></td>
<td></td>
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<tr>
<td>• If yes, can the decision wait until then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If no is the person likely to regain capacity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If yes, can the decision wait until then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If no continue with the Best Interest Assessment</td>
<td></td>
<td></td>
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**If it is practical and appropriate to do so, consult other people for their views about the person’s best interests. This may include:**

- Any individual appointed under a lasting power of attorney
- Any deputy appointed by the Court of Protection
- Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues
- Anyone engaged in caring for the person
- Close relatives, friends or others who take an interest in the person’s welfare
- An Independent Mental Capacity Advocate (IMCA)

Where the patient has nobody to act for them, other than paid carers, and a decision concerns serious medical treatment or a change in living arrangements (NHS accommodation for 28 days or more or Local Authority / Care Home accommodation for 8 weeks or more) then a referral must be made to an IMCA.

Date of referral: Made by:
### 2B) Other people Consulted (where applicable)

<table>
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<tr>
<th>Name</th>
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<th>Name</th>
<th>Designation</th>
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Taking all the above information into account, I confirm that proceeding with the assessment process is in the best interests of:

Name of patient:

**OR**

I am the attorney appointed under a Lasting Power of Attorney - Welfare made by the person / deputy appointed by the Court of Protection and agree on the patient’s behalf.

*A copy of the LPA or Court of Protection must be provided with this form.*

**NB: Lasting Power of Attorney (LPA) must have the power / scope to act in the circumstances and the LPA must be registered with the Office of the Public Guardian**

I have received written information on the Continuing Healthcare Process.

I have been informed about the potential consequences of NHS continuing healthcare eligibility, for example, ending of Direct Payments / Independent Living Fund / choice of provider and choice policy and that I have the right to decline any subsequent offer of care.

**I confirm** that it is in the best interests of (patients name) ____________ to an NHS Continuing Healthcare Checklist / Fast Track/Decision Support Tool and all subsequent reviews being undertaken.

**I confirm** that it is in the best interests of (patients name) ____________ that the information provided in this assessment be shared with health and social care staff, service providers / brokers and any agencies acting on behalf of these organisations for the purpose / process relating to NHS Continuing Healthcare and commissioning or providing care or a service to the patient. This could include the CCG and NHS England Independent Review Panel (IRP) or Parliamentary and Health Service Ombudsman (PHSO) for the purpose of dispute resolution or complaint handling.

**Signature:**

**Date:**

**Print Name:**

**Designation:**

**Relationship:**
Appendix 3 – MCA Flow Chart

1. Impairment/disturbance in functioning of mind/brain
   - No
   - Yes

2. Doubts raised about capacity to make particular decisions
   - No
   - Yes

3. Identify and clarify decisions to be made
   - No
   - Yes

4. Properly supported process enables person to make decisions in question
   - No
   - Yes

   Decide what evidence is necessary for a proper test

5. Gather and document evidence

6. Make a decision-specific test (with supported process as necessary)

7. Decide and document basis for decision

8. Repeat test as necessary

9. Take action on basis of outcome of test of capacity

Person has capacity (assumption of capacity)
Appendix 4 – Consent Form 4

Consent Form 4
(For adults who lack the capacity to consent to investigation or treatment)

This form should only be used where it would be usual to seek written consent, where an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult has capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal.

The organisation proposing and delivering the treatment should have a clear consent policy which indicates when written consent is required.

Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards.

If treatment is being provided under the authority of Part IV of the Mental Health Act 1983, different legal provisions apply, and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well).

If the adult now lacks capacity but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment, then you must abide by that refusal. For further information on the law on consent, see the Department of Health’s Reference guide to consent for examination or treatment (www.doh.gov.uk/consent). Guidance is also provided via the GMC website: Consent; “patients and doctors making decisions together”

Patient details

Patient’s surname/family name: <Surname>
Patient’s first names: <Forename>
Date of birth: <Date of birth>
Responsible health professional
Job title
NHS number (or other identifier) <NHS number>
Religion: <Gender>
Main spoken language: <Main spoken language>
Special requirements
(e.g. other language/other communication method)
Name of person with powers of attorney/ Appointed Deputy
Name of IMCA
All sections to be completed by the Health Professional proposing the procedure/intervention

A) Details of procedure or course of treatment proposed

B) Assessment of patient’s capacity (in accordance with the Mental Capacity Act) an assessment should have been carried out recently and when the person was at their optimum in respect of physical and mental health well being

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

☐ understand information about the procedure or course of treatment
☐ retain that information in their mind
☐ use or weigh that information as part of the decision-making process, or
☐ communicate their decision (by talking, using sign language or any other means)

Further details: for example, how the above judgements were reached; which colleagues were consulted; what attempts were made to assist the patient make his or her own decision and why these were not successful.

C) Patient’s best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person’s past and present wishes and feelings (in particular if they have been written down) and any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient’s best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

(Where the lack of capacity is likely to be temporary) The treatment cannot wait until the patient recovers capacity because:

D) Involvement of those close to the patient

The final responsibility for determining whether a procedure is in the best interests of the patient who lacks capacity lies with the health professional performing the procedure (unless the patient has an attorney or deputy, see section E). However, you must consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) as far as is practicable and as appropriate.

(To be signed by a person or persons close to the patient, if they wish)
I/We have been involved in a discussion with the relevant health professionals over the treatment of <Forename> <Surname> (<NHS number>)

I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name:
Relationship to patient:
Address (if not the same as patient)

Signature: ___________________________________________
Date: _______________________

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)
Yes ☐ No ☐
Details:

Independent Mental Capacity Advocate (IMCA)
For decisions about serious medical treatment, where there is no one appropriate to consult other than paid Carers, has an Independent Mental Capacity Advocate (IMCA) been instructed?
Yes ☐ No ☐
Details:

Signature: ___________________________________________
Date: _______________________

E) The patient has an attorney or deputy
Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient’s best interests, however If a legal proxy or other person involved in the decision making asks for a treatment to be provided which the doctor considers would not be clinically appropriate and
of overall benefit to the patient, the doctor should explain the basis for this view and explore the reasons for the request. If after discussion the doctor still considers that the treatment would not be clinically appropriate and of overall benefit, they are not obliged to provide it. However, as well as explaining the reasons or their decision, the doctor should explain to the person asking for the treatment the options available to them. These include the option of seeking a second opinion and applying to the appropriate court for an independent ruling.

**Signature of attorney or deputy**

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient’s best interests.

Any other comments (including the circumstances considered in assessing the patient’s best interests)

Signature: ______________________________

Date: ______________________

Name:

Relationship to patient:

Address (if not the same as patient:)

**Signature of health professional proposing treatment**

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient’s condition with those close to him or her and taken their knowledge of the patient’s views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature: ______________________________

Date: ______________________

Name (PRINT) ______________________________

Job title ______________________________
Where second medical opinion is sought, s/he should sign below to confirm agreement:

Signature: ___________________________________________

Date: ___________________________________________

Name (PRINT) ___________________________________________

Job title ___________________________________________

F) Where a decision is made to withdraw or withhold treatment

After the assessment of capacity has been made around the specific decision and a best interest meeting or discussion has occurred, then if the decision is to withhold or withdraw treatment then please record the reason and rationale for the decision below.

Warrington Clinical Commissioning Group and Warrington Primary Care would like to thank and acknowledge Warrington and Halton Hospitals who have kindly shared their consent form 4 documentation, which has been amended for local use. The content has been viewed by the Project Manager of the IMCA Service Halton, Knowsley, Warrington and St Helens

Retention

One copy to be retained in patient’s notes

Second Copy to be given to Relative/Carer/IMCA/attorney