Shropshire, Telford & Wrekin Multi-Agency

Mental Capacity Act Guidance

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INTRODUCTION

This overarching guidance supports the continued embedding of the Mental Capacity Act 2005 (“the Act”), Regulations and Code of Practice and should be read in conjunction with them.

The Mental Capacity Act 2005 came into force in 2007 and provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions.

The Act concerns paid staff, volunteers, unpaid carers and the public working with people aged 16 and over.

The Act sets out core principles and methods for assessing capacity, making decisions, and carrying out actions affecting people who may lack capacity to make decisions for themselves.

The Act also enables people to plan ahead for a time when they may lose capacity and introduced two criminal offences of ill treatment or wilful neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

The Act introduced several new roles, bodies, and powers, all of which support the Act’s provisions.

This guidance can be applied within each statutory service and within organisations in the independent and voluntary sector.

There is no substitute for reading and becoming familiar with the Code of Practice. Failure to comply with the Code can be used as evidence in civil or criminal proceedings. Whilst records ought to be kept at all times it is particularly important to keep detailed records of reasons for departing from the Code.

Aims of this Guidance

To ensure staff and all other groups working with people where there are issues about mental capacity, in Shropshire and Telford and Wrekin, work in accordance with The Act and Code of Practice.

To ensure that any assessment of capacity in Shropshire and Telford and Wrekin is carried out in line with The Act and Code of Practice and recorded appropriately.

To ensure people are empowered, protected and supported with decision making

To ensure decisions made on behalf of people without capacity in Shropshire and Telford and Wrekin are in accordance with The Act and Code of Practice and recorded appropriately.

To ensure all partner organisations in Shropshire and Telford and Wrekin comply with the Act and Code of Practice including any Policies and Procedures affected by The Act.

To assist in identifying the training needs of staff in Shropshire and Telford and Wrekin partner organisations who adopt this guidance.

MCA Context and Ethos

It has been predicted that up to 2 million[1] people in England and Wales who may lack mental capacity to make some decisions for themselves, for example people with:

- dementia
- learning disabilities
- mental health problems
- stroke and brain injuries

In addition, up to 6 million people every year may be caring for a person who lacks capacity.
The Act empowers people to make decisions for themselves wherever possible and protects people who lack mental capacity by providing a framework that places individuals at the very heart of the decision-making process. It ensures that they participate as much as possible in any decisions made on their behalf in their best interests.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595617/nmcf-chair_s-report-2016.pdf

It also allows people to plan ahead for when they might lack capacity.

The Act is underpinned by five guiding principles:

- an assumption of capacity
- all practicable steps are to be taken to support someone to make their own decisions.
- a person should not be treated as incapable of making a decision just because their decision may seem unwise or eccentric.
- decisions should always be made in the best interests of the person without capacity and
- the least restrictive intervention must always be considered.

The experience of the Covid pandemic has increased the awareness of the importance of understanding how significant proper use of the Mental Capacity Act is by professionals especially in terms of mental capacity and consent to treatment including vaccination. For those who wish to review this in more detail please see the work of the National Mental Capacity Forum Chair's Annual Report[1]

THE SCOPE OF THE MENTAL CAPACITY ACT CODE OF PRACTICE

The main provisions of the Act apply to people aged 16 and over and are set out in the Code of Practice. The following are the Chapter headings from the Code and explain the scope of its operation:

Chapter One – What is the Mental Capacity Act 2005?
Chapter Two – What are the statutory principles and how should they be applied?
Chapter Three – How should people be helped to make their own decisions?
Chapter Four – How does the Act define a person's capacity to make a decision and how should capacity be assessed?
Chapter Five - What does the Act mean when it talks about 'best interests'?
Chapter Six – What protection does the Act offer for people providing care or treatment?
Chapter Seven- What does the Act say about Lasting Powers of Attorney
Chapter Eight – What is the role of the Court of Protection and court appointed Deputies?
Chapter Nine – What does the Act say about advance decisions to refuse treatment?

[1] https://www.scie.org.uk/mca/directory/forum/reports

Chapter Ten – What is the new Independent Mental Capacity Advocate Service and how does it work?
Chapter Eleven – How does the Act affect research projects involving a person who lacks capacity?
Chapter Twelve – How does the Act apply to children and young people?
Chapter Thirteen – What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?
Chapter Fourteen – What means of protection exist for people who lack capacity to make decisions for themselves?
Chapter Fifteen – What are the best ways to settle disagreements and disputes about issues covered in the Act?
Chapter Sixteen – What rules govern information about a person who lacks capacity?

DECISIONS NOT PERMITTED UNDER MCA 2005

Certain decisions can never be made on behalf of a person who lacks capacity, or are governed by other legislation:

- consenting to sex, marriage / civil partnership or divorce / dissolution.
- decisions about parental responsibility for a child, adoption, or consent to fertility treatment.
- decisions to give, or to consent to, treatment for mental disorder of people who are liable for detention and treatment under the Mental Health Act 1983.
- decisions on voting.

The Act does not prevent action being taken to protect an adult with care and support needs from abuse or exploitation.

ROLES AND RESPONSIBILITIES

The following people are required to have regard to the Code of Practice:

- an attorney under a Lasting Power of Attorney (LPA) framework.
- a Court appointed Deputy.
- an IMCA.
- a person carrying out research approved in accordance with the Act
- someone acting in a professional capacity for, or in relation to, a person who lacks capacity.
- an individual being paid for acts for, or in relation to, a person who lacks capacity.

People acting in a professional capacity may include:

- a variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc).
- social care staff (social workers, care managers, etc).
- others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as ambulance crew, housing workers, or police officers.

People who are being paid for acts for or in relation to a person who lacks capacity may include:

- care assistants in a care home
- care workers providing domiciliary care services, and
- others who have been contracted to provide a service to people who lack capacity to consent to that service.

However, the Act applies more generally to everyone who looks after or cares for someone who lacks capacity to make decisions for themselves. This includes family carers or other carers.

DEFINITION OF MENTAL CAPACITY

The Act defines the meaning of mental capacity as follows:
"For the purposes of this Act, a person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of impairment of, or a disturbance in the functioning of, the mind or brain".

Capacity is issue, decision, and time specific. A person might lack the capacity to deal with their finances but have capacity to decide whether to consent to a particular treatment for example. An assessment of a person's capacity must therefore be based on their functional ability to make a specific decision at the time the decision needs to be made. Loss of capacity can be temporary or permanent due to a physical or medical condition e.g., brain injury, mental illness, being under the influence of alcohol or drugs.

ASSESSING CAPACITY AND BEST INTERESTS DECISIONS

The Act states that a person is unable to make a particular decision if, they are unable to do any of the following four things: -

- Understand the information relevant to the decision.
- Retain the information long enough to be able to make a decision.
- Be able to use and weigh the information in order to make a decision.
- Communicate their decision (whether verbally or otherwise)

And this is directly because of an impairment of or disturbance in the functioning of their mind or brain,

This was previously described as is often described as a two-stage assessment of capacity, however in reality it is one assessment with a clear requirement to evidence that a person's inability in the functional area is directly as a result of their mental impairment (this is described as the causal nexus).

It is important to note that there is a requirement to establish that there is an impairment or disturbance in the functioning of mind or brain, and this may be useful to confirm prior to an assessment starting.

Chapter 4 of the Code offers further guidance on defining a person's capacity and how to carry out an assessment.

The starting point must always be the assumption that people aged16 and over have mental capacity to make their own decisions unless and until it is shown that they do not. The burden of proof will fall on any person who asserts that another person lacks capacity. The person making the assertion will have to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision at the time it needs to be made and that the inability is entirely due to the mental impairment.
In summary the Code advises assessors to ask the following:

- does the person have a general understanding of what the decision is and why s/he is being asked to make it?
- does the person have a general understanding of the likely consequences of making, or not making, this decision?
- is the person able to understand, retain, use, and weigh up the information relevant to this decision as part of the process of making a decision?
- can the person communicate his/her decision (whether by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

It is particularly important to note the requirement of the Act that support is provided, so that an explanation of the information relevant to the decision must be given in a way which will meet the person's individual needs, using the most effective means of communication. Practicable steps must be taken to support the persons decision making. It is important not to set the bar too high and that understanding need only be demonstrated of the salient points.

For many decisions the so-called salient points have been established by case law over the last few years. These points will always need to be calibrated but as an example in relation to a decision about consenting to care the following salient points are usually accepted as relevant.

- With what areas the person under assessment needs support.

- What sort of support they need.

- Who will provide such support.

- What would happen without support, or if support was refused.

- That carers may not always treat the person being cared for properly, and the possibility and mechanics of making a complaint if they are not happy.

Links to more detailed guidance can be found at the end of this document.

It is also important to acknowledge the difference between unwise decisions, which a person has the right to make without this being seen as evidence of incapacity, and decisions based on a lack of understanding or inability to weigh up the information about a decision. This can form part of a capacity assessment, particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.

Assessors should appreciate that mental capacity can fluctuate and that some people may at times be quite capable of making their own decisions and at other times such as during an acute phase of illness may have Impaired mental capacity (see paras 3.12 – 3.16 and 4.26 – 4.27)[1]. In cases of fluctuating or temporary lack of capacity, particularly where the decision is a 'one off' decision, an assessment must be made of the person's capacity to make a particular decision at the time that the decision has to be made. It may be possible to put off the decision until such time as the person has recovered and regained capacity to make his/her own decision.
Some decisions are not one-off and need to be repeated over time such as the management of property and affairs or managing a physical health condition. Although capacity is time-specific, in such a case, it will usually be appropriate to take a broad view as to the 'material time' during which the person must be able to take the decisions in question. If there are only limited periods when the person is able to take their own decisions, it will usually be appropriate to proceed on the basis that, they lack capacity to do so.
This is particularly so where the consequences for the person are very serious if they are assessed as taken to have capacity when this is only true for a very small part of the time. The courts have sometimes described this as 'zooming out' to ask a macro-question if appropriate. If this approach is taken, you should keep the person's decision-making ability under review, and reassess if it looks like the balance has tipped so that they have capacity to take the relevant decision(s) more often than not.

[1] MCA 2005 Code of Practice

Complex decisions are likely to need more formal assessments. A range of professional opinions may be needed in order to have the best picture of the person but the final decision about a person's capacity must be made by the person intending to implement the decision known as the decision maker.

RECORDING AND SHARING INFORMATION

Apart from day-to-day decisions, a formal record of the assessment of capacity and the best interest decision making process must be produced. All partner organisations implementing this guidance will follow best practice in assessing capacity and making best interest decisions and will demonstrate this in their recording which as a minimum will provide evidence of

- a description of the decision required.
- the steps taken to support the person to make their own decision.
- robust evidence from a meeting with the person which addresses the four aspects of the functional test.
- evidence of the mental impairment
- a conclusion which demonstrates the causal link with the diagnosis

The presumption of capacity will be promoted at all times.
For day-to-day decisions the decision maker must be able to demonstrate they had a "reasonable belief" that the individual lacked capacity to make the decision in question, and it was in their best interests to take the action they took. They must be able to describe their decision making if necessary. It is not necessary to record this in as much detail as for more complex decisions, but the recording must demonstrate that the Act has been followed.

In various sections of this guidance there is information about the importance of recording information accurately including how to document assessments, consultation and keeping accurate records using the various templates provided in the appendices. It is important to note that capacity assessments are both time and decision specific and this should be clear from the records the practitioner makes.

Learning from statutory case reviews both locally and nationally[1] has emphasised that capacity assessments needed to be completed thoroughly using recognised templates (as available in this document) and communicated with relevant party agencies. For example, when considering if someone has capacity to make decisions about whether someone should continue to reside in residential care then the decision-maker would need to ensure that information is shared with the care home staff, the GP, Adult Social Care, and mental health nurse etc. These agencies should review the information they have in order to help with the process.

[1] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

Practitioners should be aware that whenever a situation arises in which a person's capacity about decisions associated with areas of risk were safeguarding concerns are present there is a need for clarity about how the Mental Capacity Act is being used to empower and or protect the person. This will involve formal assessments of capacity and practitioners should consider which other agencies will have relevant information to best understand the circumstances and how they should be involved in the assessment. This duty to consult also extends to best interest decisions and the need to speak to "family members or friends who take an interest in their welfare…...anybody working out a person's best interests must consult these people, where possible, and take their views into account."[1]

The national review of Safeguarding Adult Reviews found that recording of capacity assessment in some cases were noted to be poor. Professionals recording capacity assessments should always be clear about the decision and record this formally.

It is important to balance the requirement for consultation and information sharing against the right to confidentiality of the person lacking capacity. That right should be protected so that consultation only takes place where relevant and with people whom it is appropriate to consult. For example, it is unlikely to be appropriate to consult anyone whom the person had previously indicated should not be involved. However, it is acceptable to share information with others where it is in the person's best interests. Further detail is in Chapter Sixteen of the Code of Practice

The Code of Practice is clear that the more professional the person's role the more is required of them in demonstrating a reasonable belief. Para 6.33[1] "If healthcare and social care staff are involved, their skills will affect what is classed as reasonable. For example, a doctor assessing someone's capacity to consent to treatment must demonstrate more skill than someone without medical training".

WHO ASSESSES CAPACITY

Under the Act, many different people may be required to assess capacity and make best interest decisions on behalf of someone who lacks capacity. The person

[1] MCA 2005 Code of Practice 10.3

who needs the decision to be made is responsible for these processes and is referred to as the 'decision-maker' (see paras 4.38 – 4.43)[1].

For most day-to-day actions or decisions, the decision-maker will usually be the carer most directly involved with the person at the time.

Where the decision relates to social care, the person responsible for the care management of the individual is usually the decision-maker.

Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.

Where nursing or paid care is provided, the nurse or paid carer will usually be the decision-maker.

However, if a Lasting Power of Attorney has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority.

For a legal transaction (for example, making a will), a solicitor or legal practitioner must assess the client's capacity to instruct them. They must assess whether the client has the capacity to satisfy any relevant legal test. In cases of doubt, they should get an opinion from a doctor or other professional expert.

The Act covers a wide range of decisions made, or actions taken, from relatively minor day to day matters to major life-changing events. They can include matters in connection with personal welfare, health and medical treatment and the management of property and financial affairs. An assessment must be carried out when a person's capacity is in doubt. After someone has made an assessment that an individual lacks mental capacity, with respect to a particular matter, that person may then perform acts in respect of the care or treatment, and in the best interests of, the person lacking capacity.

The more serious the decision, the more formal the assessment of capacity may need to be. For example, a professional, such as a psychiatrist or psychologist, may be asked for an opinion to assist with the assessment and where consent to medical treatment or examination is required, the doctor proposing the treatment must decide whether the patient has capacity to consent. In some cases, a

[1] Mental Capacity Act Code of Practice

multidisciplinary approach is best, using the skills and expertise of different professionals.

The Decision Maker will only have a defence for their actions, where the person lacks capacity to consent to them, if they are able to clearly demonstrate their use of the MCA to assess capacity and make any relevant best interest decisions.[1]

EXECUTIVE FUNCTIONING

It has been recognised that there are complex situations in which concerns arise about executive dysfunction. This matter has been addressed specifically in the revised draft Code of Practice to the Mental Capacity Act. Whilst there is no publication date for the new Code it did recognise the "common area of difficulty……where a person with an acquired brain injury gives coherent answers to questions, but it is clear from their actions that they are unable to give effect to their decision. This is sometimes called an impairment in their executive function. If the person cannot understand (and/or use and weigh) the fact that there is a mismatch between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated mismatch between what the person says and what they do. This means that in practice it is unlikely to be possible to conclude that the person lacks capacity as a result of their impairment on the basis of one single assessment."

There are further explorations of the impact of what is also referred to as "Dysexecutive Syndrome" from case law discussions[2]. Frequently the focus is upon people with acquired brain injuries were there is "evidence of repeated mismatch/divorce between saying and doing." This has been referred to as the "the frontal lobe paradox," where those with frontal lobe damage can perform well in interview and test settings, despite marked impairments in everyday life.

It is therefore critical that when assessing capacity practitioners take account of the potential existence of an impairment of the mind or the brain that has an impact on executive functioning despite the existence of verbal skills. Equally practitioners "should also guard against" believing a gap between being able to seemingly verbalise an issue of concern that needs an action and then not taking the actions does not necessarily mean the person lacks capacity about that decision.

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[1] https://www.legislation.gov.uk/ukpga/2005/9/section/5
[2] https://www.mentalcapacitylawandpolicy.org.uk/executive-capacity-and-the-court-of-protection/

Practitioners should remember that section1(4) of the Mental Capacity Act states: P is not to be treated as unable to make a decision merely because he makes an unwise decision.

The Social Care Institute of Excellence (SCIE) has provided valuable resources to assist practitioners when dealing with these issues.[1]

SCIE have stated that there is no single definition of executive function, but it involves goal-oriented behaviour, including: planning, organisation, fluency, inhibition, mental flexibility, and abstract reasoning. Disorders most likely to be prevalent when undertaking assessments which give raise to complex interpretations around capacity and executive functioning can include conditions that originally had a sudden onset with scope for improvement (even after some time) e.g., stroke, blunt external force (road traffic accident) especially involving injury to the frontal lobe and conditions with slow progressive deterioration e.g., frontotemporal dementia. It is also stressed there is a need to consider contextual information; information about the type of impairment of brain; the history about change in the person's goal directed behaviour; collateral sources of information from people with longitudinal knowledge of the person and information about how the person makes decisions outside of structured environments.

[1] https://www.scie.org.uk/mca/directory/forum/nmc-webinars/executive-dysfunction Executive dysfunction and the MCA

SUPPORTING DECISION MAKING

Before deciding that someone lacks mental capacity to make a particular decision, it is important to take all practicable steps to enable them to make that decision themselves. Chapter 3 of the Code suggests a range of practicable steps that can be taken to assist individuals to make decisions and assessors are strongly advised to refer to this whenever faced with an assessment of capacity. Broadly though, the following questions should be asked:

- Does the person have all the relevant information needed to make the decision in question? If there is a choice, has information been given on any alternatives? (See para 3.9)1
- Could the information be explained or presented in a way that is easier for the person to understand? (See para 3.10)[1.]
- Can anyone else help or support the person to make choices or express a view, such as a relative, an independent advocate or someone to assist communication? (See para 3.11)[1.]
- Are there particular times of the day when the person's understanding is better or particular locations where they feel more at ease? (See paras 3.13 and 3.14)[1.]
- Can the decision be put off until the circumstances are right for the person concerned?

Some people may need help or support to be able to make a decision or communicate a decision, but that does not automatically mean that they cannot make that decision. An assumption about someone's capacity cannot be made merely on the basis of the person's age or appearance, condition, or aspect of his/her behaviour (see paras 4.7 to 4.9)[1]. Further, a person is 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 guidance covers all of those aged 16 and over and is written primarily for health and social care practitioners, individuals, carers and families.

NICE have issued guidance on supported decision making which aims to [i] support as many people as possible to make their own decisions and [ii] to keep those who lack capacity at the centre of decision making.

There is specific guidance on supported decision making; advance care planning; assessing mental capacity to make a specific decision at a particular time and best interest decision making.[2]

MAKING BEST INTERESTS DECISIONS

1 MCA 2005 Code of Practice

[2] https://www.nice.org.uk/guidance/ng108

Where a person lacks mental capacity to make a particular decision the Act allows others (those who are either legally appointed to act or best interests decision makers) to make decisions on behalf of the person who lacks capacity.

Decision-makers should always refer to the full Code of Practice when trying to determine the best interests of a person who lacks capacity.

The Act states that where a person lacks capacity for a particular decision then any act done, or any decision made, for or on behalf of a person who lacks capacity must be done, or made, in that person's *best interests*.

The intention of the principle is to provide some consistency in how decisions are made on behalf of people lacking capacity to make their own decisions. Compliance with the statutory checklist described below provides a framework for gathering evidence and for decision making. Following this process ensures that the decision-maker is protected from liability.

The exception to this is where someone has previously made an Advance Decision to refuse medical treatment while they had the capacity to do so. If the advance decision is valid and applicable it must be adhered to when they lack capacity.

The term 'best interests' is not defined in the Act but chapter 5 of the Code explains how to determine the best interests of a person who lacks capacity by reference to a "statutory checklist" which must *always* be followed in any situation where a decision is being made or an act is being done for a person lacking capacity.

The checklist can be broadly summarised as follows:

Equal consideration and non-discrimination – i.e., people with impaired mental capacity are not to be subject to discrimination or treated any less favourably than anyone else. Don't make assumptions about someone's best interests merely on the basis of the person's age or appearance, or any condition or aspect of his/her behaviour (such as talking too loudly or laughing inappropriately), which might lead others to make unjustified assumptions about what might be in the person's best interests (see paras 5.16 – 5.17)[1].

[1] MCA 2005 Code of Practice

Considering all relevant circumstances - try to identify all the issues and circumstances relating to the decision in question which are relevant to the person who lacks capacity (see paras 5.18 - 5.20)[1].

Permitting and encouraging participation - ensure that all reasonable efforts are made to help the person participate in the decision-making process to the fullest possible extent. Even if the person lacks capacity to make the decision in question, /he may have views on matters affecting the decision, and on what outcome would be preferred (see paras 5.21 – 5.24)[1].

Regaining capacity - the decision-maker must consider whether the individual concerned is likely to regain the capacity (e.g. after receiving medical treatment) to make that particular decision in the future and if so, when that is likely to be. It may be possible to put off the decision until the person can make it him/herself (see paras 5.25 – 5.28)[1].

Special considerations for life-sustaining treatment – in summary the decision must not be motivated in any way by a desire to bring about the person's death or by any value judgements about their quality of life (see paras 5.29 – 5.36).

The person's wishes and feelings, beliefs and values –There is a need to make all reasonable efforts to find out the person wishes feelings, beliefs and values (e.g., religious, cultural or moral) that would be likely to influence the decision in question, in the past as well as trying to seek their current views. Past or present wishes must be considered to have great significance in determining a person's best interests **(**see paras 5.37 – 5.48)[1].

The views of other people –family members, partners, carers and other relevant people are to be consulted (if it is "practicable and appropriate") as to what might be in the person's best interests. The decision-maker has a duty to take into account the views of the following people, where it is practical and appropriate to do so:

- Anyone previously named by the person lacking capacity as someone to be consulted.
- Anyone engaged in caring for the person or interested in the person's welfare.
- Any attorney appointed by the person under a Lasting Power of Attorney.
- Any deputy appointed by the Court of Protection.

[1] MCA 2005 Code of Practice

- For decisions about major medical treatment or a change of residence and where there is no-one to consult with other than paid professionals, an IMCA must be appointed.

Those consulted will be asked what they consider to be in the person's best interests and whether they can provide any information on their wishes, feelings, values or beliefs (see paras 5.49 – 5.55)[1].

Should a best interest decision be made that departs from the person's wishes or feelings or their preferences (i.e., Not an Advance Decision to Refuse Treatment), the decision-maker should record the reasons for that departure and be prepared to justify them if challenged. It is important to note the distinction between a written statement expressing preferences, as opposed to a statement which constitutes an Advance Decision to refuse specified treatment, an Advance Decision is legally binding and must be respected if valid and applicable (Chapter 9 of the Code).

Section 4 of the Act confirms the best interest principle, and the duties to be carried out in determining best interests.

SETTLING DISPUTES

In some cases (see para 4.54)[1] there will be a legal requirement that a formal assessment of capacity be carried out. In other cases, a judgement will need to be made as to whether it is appropriate or necessary to involve a doctor or other expert in assessing the person. Any of the following factors might indicate the need for further professional involvement, or a second opinion:

- the decision is complicated, or its consequences are serious.
- where the person concerned disputes a finding of a lack of capacity.
- where there is disagreement between family members, carers and/or professionals as to the person's capacity.
- where the person concerned is expressing different views to different people (perhaps through trying to please each one or tell them what s/he thinks they want to hear).
- where the person's capacity to make a particular decision may be subject to challenge, either at the time the decision is made or in the future.
- where the person concerned is repeatedly making decisions that put him/her at risk or could result in preventable suffering or damage.
- Where there is an allegation or suspicion of abuse or neglect of an adult who lacks capacity.

[1] MCA 2005 Code of Practice

There may be circumstances in which a person whose mental capacity is in doubt refuses to undergo an assessment of capacity or refuses to be examined by a doctor. It will usually be possible to persuade someone to agree to an assessment if the consequences of refusal are carefully explained. It will normally be possible for an assessment to proceed so long as the person does not object and it is considered to be in the person's best interests. Further advice is contained at paras 4.57 – 4.59 onwards[1].

Finally, anyone supporting a person who may lack capacity should not use excessive persuasion or "undue pressure". This might include behaving in a manner which is overbearing or dominating.

When trying to determine the best interests of a person lacking capacity, a decision-maker may be faced with competing or conflicting concerns. For example, family members, partners and carers may disagree between themselves about what is in the best interests of the person lacking capacity or may have different memories as to the previously expressed views of the person concerned. The decision-maker will need to find a way of balancing these concerns or deciding between them. (See paras 5.64 – 5.67)[1].

Ultimately, it is up to the person charged with making the decision, or carrying out the act in question, to reach a conclusion about the best interests of the person who lacks capacity, having considered all relevant circumstances, and worked though the statutory checklist.

If someone wishes to challenge a determination, about capacity or best interests, made by a decision-maker, there are a number of options that could be explored including:

- Involving an advocate, who is independent of all the parties involved in the decision, to act on behalf of the person lacking capacity (see para 5.69)[1].
- Getting a second opinion (for example, concerning the need for medical treatment).
- Holding a formal or informal case conference.
- Attempting some form of mediation (although reaching a consensus will not determine best interests of the person lacking capacity).
- Pursuing a complaint through the Council's or the organisations Complaints procedures.

[1] MCA 2005 Code of Practice

Healthcare complaints

There are formal and informal ways of complaining about a patient's healthcare or treatment. Healthcare staff and others need to know which methods are suitable in which situations. They should be able to advise those with concerns about their organisations policies and processes.

Any complaints that are about the potential abuse of an adult with care and support needs should **always** be referred into the Adult Safeguarding process managed by the Local Authority who will advise further.

The Patient Advice and Liaison Service (PALS) provide an informal way of dealing with problems before they reach the complaints stage. PALS operate in every NHS Trust and Integrated Care Board in England. They provide advice and information to patients (or their relatives or carers) to try to solve problems quickly. They can direct people to specialist support services (for example, advocates, mental health support teams, social care or interpreting services). PALS do not investigate complaints. Their role is to explain complaints procedures and direct people to the formal NHS complaints process, if necessary. Formal NHS Complaints procedures concern something that happened in the past that requires an apology or explanation.

Social Care complaints

A service provider's own complaints procedure should deal with complaints about:

- the way in which care services are delivered.
- the type of services provided.
- a failure to provide services.

Any complaints that are about the potential abuse of an adult with care and support needs should always be referred into the Adult Safeguarding process managed by the Local Authority who will advise further.

Care agencies contracted by local authorities/ICBs or registered with the Care Quality Commission (CQC) are legally obliged to have their own written complaints procedures. This includes residential homes, agencies providing care in people's homes, nursing agencies, adult placement schemes, ambulance services, independent healthcare, dentist, doctors. The procedures should set out how to make a complaint and what to do with a complaint that cannot be

settled locally.

Disagreements about how an LPA or Deputy is acting.

If someone is questioning the actions of an attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney or a deputy appointed by the court this is different to concerns about abuse (including financial), which is a safeguarding matter and appropriate concerns should be raised.

In these circumstances, where it is felt that the attorney or deputy is not acting in the person's best interests the most appropriate action would be to contact the Office of the Public Guardian (OPG) for guidance and advice.

Report a concern about an attorney, deputy or guardian - GOV.UK (www.gov.uk)

Office of the Public Guardian
opg.safeguardingunit@publicguardian.gov.uk
Telephone: 0115 934 2777
Textphone: 0115 934 2778
Monday to Friday, 9:30am to 5pm
Wednesday, 10am to 5pm

THE COURT OF PROTECTION

The MCA created a new specialist court, the Court of Protection, with jurisdiction to deal with decision making for adults who lack capacity. The Court can make decisions about property and affairs, and personal health and welfare matters.

The Court of Protection has the powers to:

- Decide whether a person has the capacity to make a particular decision for themselves.
- Make declarations about "best interests".
- Appoint Deputies to make decisions for people lacking capacity to make those decisions,
- Decide whether a Lasting Power of Attorney, Enduring Power of Attorney or advance decision is valid.
- Remove Deputies or Attorneys who fail to carry out their duties.

The Code of Practice suggests that it may be necessary for some decisions to be taken by the Court including:

- Particularly difficult decisions
- Disagreements that cannot be resolved in any other way.
- Situations where ongoing decisions may need to be made about the personal welfare of a person who lacks capacity to make these decisions for themselves.

Applications to the Court of Protection

Shropshire Council staff must follow the Court of Protection protocol in any situation where the Courts involvement may be required.

All other organisations adopting this guidance any potential application to the Court of Protection must be agreed in advance with a person of suitable seniority as agreed within each partner organisation.

The Court of Protection and Serious Medical Treatment

Some treatment decisions are so serious, that the Court of Protection should be involved unless the person has previously made a Lasting Power of Attorney appointing someone to make healthcare decisions for them, or they have made a valid Advance Decision to refuse the proposed treatment, or there is unanimous agreement that the act or decision would be in the persons best interests.

Legal advice should be considered before making decisions about withdrawing life sustaining artificial nutrition or hydration as case law is evolving the understanding of this area. However, where there is a consensus from all involved including family, the Court may not need to be involved, but seeking legal advice should help determine the correct course of action.

The Court of Protection **must still** be asked to make decisions relating to:

- The proposed non-therapeutic sterilisation of a person who lacks capacity to consent (e.g., for contraception purposes).

More detail can be found in Chapter 8 of the Mental Capacity Act 2005 Code of Practice

Court of Protection and the Appointment of Deputies

If the person lacking mental capacity has not appointed or is unable to appoint an Attorney and decisions need to be made on their behalf, then an application can be made to the Court of Protection. All other options should have been explored prior to seeking permission to apply to the Court of Protection.

Family members or others concerned with the welfare of a person may also apply to be a Deputy and in which case statutory services may be consulted.

The Court of Protection aims to make specific decisions but where there are several ongoing issues, they can appoint a Deputy to make decisions on behalf of the person.

The role of the Court of Protection and Deputies is described in detail in Chapter Eight of the Code of Practice.

LASTING POWER OF ATTORNEY (LPA)

An LPA is a legal document that allows a person (the Donor) with capacity to choose someone (the Attorney) that they trust to make decisions on their behalf at a time in the future when they may lack the mental capacity to make those decisions themselves.
An LPA can only be used after it is registered with the Office of the Public Guardian (OPG).
There are two different types of LPA: a 'personal welfare' LPA and a 'property and affairs' LPA.

Personal Welfare LPA

A Personal Welfare Lasting Power of Attorney allows someone to plan ahead by choosing one or more people to make decisions on their behalf regarding personal healthcare and welfare.
These decisions can only be taken by somebody else when the person lacks the capacity to make them for themselves.
The Attorney(s) will only be able to use this power once the LPA has been registered and once the person lacks capacity to make the required decision themselves.
The attorney can be given the power to make decisions about any or all personal welfare matters, including healthcare.
This could involve some significant decisions such as:

- giving or refusing consent to particular types of health care including medical treatment decisions.
- decisions about whether the person continues to live at home or whether residential care would be more appropriate.

If the Attorney(s) is to have the power to make decisions about 'life-sustaining treatment', this must be expressly stated using the appropriate sections of the LPA form.
The Attorney(s) can also be given the power to make decisions about day-to-day aspects of personal welfare, such as diet, dress, or daily routine.
It is up to the Donor which of these decisions the Attorney is allowed to make.

Property and Affairs LPA

A Property and Affairs Lasting Power of Attorney allows someone to plan ahead by choosing one or more people to make decisions regarding property and financial affairs.
A property and affairs Attorney can be appointed to act whilst the person still has capacity as well as when they lack capacity. For example, it may be easier to give someone the power to carry out tasks such as paying bills or collecting benefits or other income. This might be because it is difficult to get about or to talk on the telephone, or the person may be out of the country for long periods of time.
The Attorney(s) can be given the power to make decisions about any or all of the property and affairs matters.
This type of LPA does not allow the Attorney to make decisions about personal welfare.

Who can make an LPA?

Anyone aged 18 or over, with the capacity to do so, can make an LPA appointing one or more Attorneys to make decisions on their behalf. One person can be appointed to deal with finances and another to deal with health and welfare decisions for example.

How to make an LPA

To make an LPA, the person must use a special form, also known as the instrument; it can be downloaded from the Office of the Public Guardian (OPG) website www.publicguardian.gov.uk or copies can be obtained from OPG Customer Services and legal stationers.
Although an LPA can be made at any time, it cannot be used until it has been registered with the OPG.
There is also additional guidance about how to complete the form and guidance booklets about making an LPA on the OPG website.

The forms have been designed to be as simple to complete as possible but an LPA is a very important and powerful document so people may want to seek advice from someone with experience in preparing them, such as a solicitor.

Professionals should always ask to see evidence confirming that a person is lawfully acting as an LPA or deputy. It is also possible to do an online search by completed a Form OPG100

Find out if someone has a registered attorney or deputy - GOV.UK (www.gov.uk)

THE INDEPENDENT MENTAL CAPACITY ADVOCATE

The purpose of the Independent Mental Capacity Advocacy Service is to help people who lack capacity, and who are un-befriended, to make important decisions.

An IMCA **must** be instructed where:

- there is a decision to be made regarding either serious medical treatment (SMT) or change of accommodation.
  AND
- the person has no close family or friends appropriate to consult to represent their views (para 10.74)[1]
  AND
- the person has been deemed by the Decision Maker not to have capacity to make that decision in accordance with the assessment of capacity as defined in the Act.

Serious Medical Treatment is not defined but includes providing, withholding or stopping serious medical treatment. For a single treatment it is where the risks and benefits are finely balanced, or the choice of treatments is finely balanced or what is proposed may have severe consequences for the person.

Change of accommodation means more than 28 days in hospital or more than 8 weeks in a care home.

An IMCA **may** be instructed in relation to an Adult Safeguarding Concerns Investigation or an Accommodation Care Review if it would be of benefit to the person to do so.

[1] MCA 2005 Code of Practice

Adult Safeguarding Concerns

In Adult Safeguarding situations, access to IMCAs is **not restricted** to people who have no one else to support or represent them.

The Code equally applies to a person:

- who may have been abused.
- who has been neglected.
- who is alleged to be the abuser.

Accommodation Care Reviews

Regulations specify that the local authority has the power to instruct an IMCA in accommodation care reviews if the following three requirements are met:

- the local authority must have arranged the original accommodation.
  and
- the person must lack capacity.
  and
- there is no other person appropriate to consult.

The IMCA Service provider for:-

Shropshire	Telford and Wrekin
Voiceability Head Office Unit 1 The Old Granary Westwick, Oakington Cambridge, CB24 3AR Telephone: 0300 303 1660 Website: https://www.voiceability.org/ Our services in Shropshire https://www.voiceability.org/support-and-help/services-by-location/shropshire Email: helpline@voiceability.org	POhWER PO Box 17943, Birmingham, B9 9PB Website: https://www.pohwer.net/ Telford and Wrekin https://www.pohwer.net/telford-and-wrekin Telephone: 0300 456 2370 Email: pohwer@pohwer.net

RESEARCH INVOLVING PEOPLE WHO MAY LACK CAPACITY

It is important that research is able to involve people who lack capacity, to provide knowledge about the causes of incapacity and about the diagnosis, conditions, treatment, care and needs of people who lack capacity.

The MCA introduces a number of safeguards to protect people taking part in such research, such as:

- Family member or unpaid carers must be consulted about any proposal and agree that the person can be part of the research. If such a person cannot be identified, then the researcher must identify a person who is independent of the research project to provide advice on the participation of the person who lacks capacity in the research.
- If the person without capacity shows any sign that they are not happy to be involved in the research, then 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 mental capacity.
- The committee will also have to approve plans to deal with people who consented to join a long-term research project but lost capacity before the end of the project.

The person's past or present wishes and feelings and values are most important in deciding whether they should take part in research or not. Someone involved in a research project may ask you if you know what the person's feelings are. Part of a research project may be carried out when you are providing care or treatment for a person, and you may be asked to let the researchers know if the person seems upset about any aspect of it. However, para 11.23[1] provides that the consultee cannot be a professional or paid care worker.

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 will need to follow the guidance given in the Code of Practice.

[1] MCA 2005 Code of Practice

RESTRAINT, RESTRICTION AND DEPRIVATION OF LIBERTY

The MCA allows for restraint to be used if specific criteria are met.
If restraint is being considered, then there must be objective reasons to justify it. It must be shown that the restraint is necessary to prevent harm and is proportionate to the likelihood and risk of harm to the person and it must be the minimum amount of force for the shortest time possible.

It is important to note that section 5 of the Act allows for restriction and restraint but does not allow a person to be deprived of their liberty.

Where a care or treatment plan is in place with restrictions which meet the acid test and give rise to a deprivation of liberty (that is that the person is not free to leave and is under complete or continuous supervision and control) this must be authorised in order for it to continue.

For people in Care Homes and Hospitals such authorisations are given under the Deprivation of Liberty Safeguards procedure, in all other cases they are given by the Court of Protection. For further guidance refer to the DoLS Code of Practice and the Multi Agency DoLS Guidance and Procedure.

Appendix 1

Mental Capacity Assessment Tool **(with thanks to Shropshire Council)**	
This document is to be used when a formal assessment of capacity needs to be made (e.g., a new care plan, a move into residential care, consent to treatment or discharge from hospital)	
Name: **Address:**	**Date of birth:** **Reference number:**
What is the decision to be made:	
The following practicable steps have been taken to support the person to make the decision [see appendix 2]. ***Please describe these steps:***	
Functional questions:	
1. Is the person able to understand the information relevant to the decision? *Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.*	**YES/NO**
2. **Is the person able to retain the information relevant to the decision?** *Record how you tested whether the person could retain the information long enough for them to make a decision and your findings.*	**YES/NO**
3. Is the person able to use or weigh that information as part of the process of making the decision? *Record how you tested whether the person could use and weigh the information and your findings.*	**YES/NO**
4. Is the person able to communicate their decision (whether by talking, using sign language or any other means? *Record your findings about whether the person can communicate the decision.*	**YES/NO**

If any of the answers above are NO please complete the following information
Does the person have an impairment or disturbance in the functioning of mind or brain? YES/NO **If yes please describe**
Conclusion (including any further input needed). **If the person is unable to make the specific decision, is this because of the impairment of, or disturbance in the functioning of the mind or brain? Explain how below**
OUTCOME: **The person has capacity for the specific recorded decision.** ☐ **The person lacks capacity for the specific recorded decision.** ☐

Appendix 2

ASSESSMENT OF CAPACITY CHECKLIST

Preparation	Prompts
Timing	At what time of day is the person most alert? Will capacity improve if the decision is delayed? Consider the effect of medication on timing.
Location	Where do they feel most at ease? Is there a location which may aid decision making? Ensure there are no interruptions, or distractions?
Communication	Do you need appropriate communication aids including pictures, objects other visual aids? Consult family members/carers about preferred communication methods. Enlist the help of others who are trusted and known well by the person. Be aware of cultural or religious factors. Do they need to talk to someone who has made a similar decision? Are there any publications which may aid understanding?
Support	Do you need an independent advocate? Does anyone else need to be with them?
History	What is known about the person's history of decision making? Have they made a similar decision before? Do we know what their decision would have been before any loss of capacity? What are their hopes and aspirations? What is the view of close relatives or friends?

Appendix 3 MAKING BEST INTEREST DECISIONS CHECKLIST

Assessment headings	Prompts
What is the decision to be made?	Not all headings are relevant but MUST be considered before they can be disregarded.
Equal consideration and non discrimination	Do not make assumptions about someone's best interest based on age or appearance condition or type of behaviour e.g. visible issues such as Downs Syndrome, skin colour or dress, learning difficulties, age related illness or temporary conditions such as drunkenness. No preconceptions or negative assumptions. Objective assessment must be carried out.
Consider all relevant circumstances	Follow all steps in checklist and other circumstances that you are aware of, and it is reasonable to consider. Try to identify all the issues and circumstances relating to the decision which are most relevant.
Regaining capacity	Consider if the person is likely to regain capacity. If so, can the decision be delayed? Will the decision be influenced by whether they are likely to regain capacity? Can the lack of capacity be treated, or will it decrease in time? e.g. alcohol/ shock Could new skills be learned to improve capacity? Can they learn a new form of communication? Does the condition fluctuate?
Permitting and encouraging participation	Involve the person to the fullest extent. Consult and seek their views. Take time to explain. Provide appropriate support. Use simple language, pictures, photographs. Consider time, location, use of friend or advocate to gain views.
Special consideration for life sustaining treatment	The decision maker must not be motivated by the desire to bring about the person's death. Value judgements should not be made about the quality of a person's life.
Assessment headings	Prompts

Persons wishes feelings and beliefs	What is known about their past and present wishes? Is there an Advance Decision? Was anything written whilst they had capacity? - if decision departs from their written statement reason must be recorded and justified. Take reasonable efforts to find out what they would have wanted as well as current views. Their past/present wishes and feelings may now conflict and must be weighed along with all other factors. Can they express their wishes and feelings by their behaviour? e.g., pleasure or distress Ensure as far as possible wishes and feelings are not influenced by others. Consider use of independent advocate Values and beliefs are important, what was their religious or political background. Note what is “reasonably ascertainable” in an emergency will be different from less urgent situations. (See Code for guidance on advance decisions regarding medical treatment).
Views of other people	Consider consultation with family members, partners, carers, anyone named or nominated by the person lacking capacity, anyone involved in their welfare, any attorney appointed, any deputy appointed. Ask them: 1) what do they think is in the person’s best interest? 2) what information can they provide on the wishes/feelings/values and beliefs of the person? Consult only as “practicable and appropriate”. Show you have thought carefully about who to consult. If not consulting family carers etc keep clear record of reasons.
Making the decision	What is the least restrictive intervention i.e., what will restrict their rights and freedoms as little as possible?
What is the decision	Record the decision made.

Appendix 4

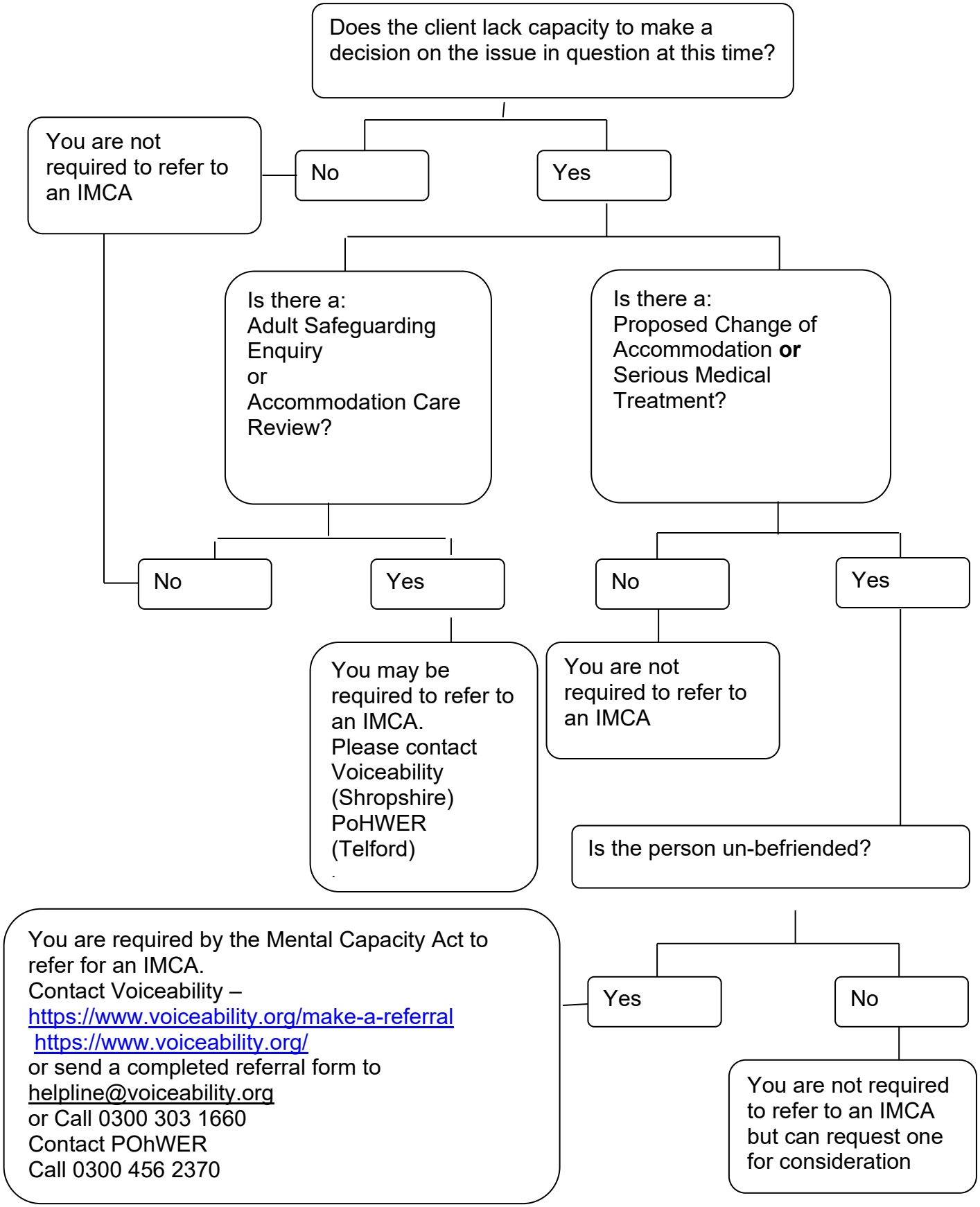
BEST INTERESTS DECISION MAKING TOOL This can be used as an Agenda and format for minutes **or** for recording a best interest decision. (*With thanks to Shropshire Council*)		
Date of meeting		
Person's name		
Decision makers name		
Decision to be made.		
Attendees (if a meeting is held)		
Area	**Action for Chair**	**For Minutes**
Welcome by the Chair including statement on capacity.	*A best interest's decision can **only** be made where the person lacks capacity to make the specific decision themselves. Explain the particular decision on capacity.*	Record any necessary comments on decision specific capacity
Introductions	*Introduce all those present at the meeting. If anyone has been specifically excluded in the persons best interests, this should also be explained.*	List
Confidentiality statement	*The Chair should make a statement about the confidentiality of the meeting.*	Record
Explanation of meeting purpose and format	*This meeting will proceed by following the statutory checklist for decision making as described in the*	Record the statement

	Mental Capacity Act 2005 and the Code of Practice. If any section is not relevant it can be omitted but only after it has been considered in the meeting.	
Equal consideration and non-discrimination	*This meeting will not make assumptions about the person's best interest based on their age or appearance or their condition. It will be an objective process without preconceptions or negative assumptions.*	Record any specific detail such as specific issues of culture or religion.
Consider all relevant circumstances.	*Use this time to have an open discussion about the wider aspects of the decision to be made.*	Record everything that may impact upon the decision to be made
Regaining capacity	*Consider whether the person will regain capacity in time to make the decision or whether it can be delayed.*	Record the conclusion.
Permitting and encouraging participation	*Discuss here to what extent the person has been included in the meeting, how their views have been sought outside the meeting.*	Record how the person has been supported to participate.
Persons wishes feelings, beliefs and values.	*What is known about the person's past and present wishes?* *Was anything written whilst they had capacity? Record what you know about their values and beliefs, religious or political background that may impact on the decision, remember that the persons wishes are paramount in decision making but this does not mean they call always be adhered to.*	Record the person's wishes, feeling, beliefs and values in relation to the specific decision.
Views of other people	*What are the views of family members, partners, and carers? Anyone named or nominated by the person lacking capacity. Anyone involved in their welfare.*	Record the views of others.

	Any attorney or deputy appointed. *Specifically- what they think is in the person's best interests? And what information they can provide on the wishes/feelings/values and beliefs of the person. If there is no-one to consult with then an IMCA will be involved. Do not omit dissenting views.*	
Life sustaining treatment decisions	*Discuss whether it is a life sustaining treatment decision and if so, the decision maker must not be motivated by the desire to bring about the persons death. Value judgements should not be made about the quality of a person's life.*	Record whether this applies or not.
Burdens and Benefits balance sheet .	*It will be useful to identify the benefits and burdens of each **available** option. Addressing the following areas: medical, welfare, social, emotional and ethical may help for complex cases.*	You should record this as a balance sheet
What is the decision to be made in the person's best interests		
Why is this decision the less restrictive option		
Any further actions needed	*Consider any further actions such as obtaining a legal opinion or other professional opinion or any application to the Court of Protection.*	Record further actions clearly as well as specifying who will carry out the actions.

Appendix 5

Should I refer to an IMCA?



Appendix 6
FORMAL COMPLAINTS PROCEDURES

NHS complaints procedure

The formal NHS complaints procedure deals with complaints about NHS services provided by NHS organisations or primary care practitioners. As a first step, people should try to settle a disagreement through an informal discussion between:

- the healthcare staff involved.
- the person who may lack capacity to make the decision in question (with support if necessary).
- their carers.
- any appropriate relatives.

If the person is still unhappy after a local investigation, they can submit a formal complaint to either the NHS organisation that provides the service or the NHS organisation that commissions, or pays for, the service.

Integrated Care Boards commission most secondary care such as hospital care and some community care. You can get details about NHS Shropshire, Telford and Wrekin Integrated Care Board at
https://www.shropshiretelfordandwrekin.nhs.uk/
If you would like help making your complaint, the Independent Health Complaints Advocacy Service (IHCAS) can provide advice.

If your problem persists or you are not happy with the way your complaint has been dealt with locally, you can complain to the Parliamentary & Health Service Ombudsman.

You can contact the ombudsman on 0345 015 4033, email: phso.enquiries@ombudsman.org.uk or write to: The Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London SW1P 4QP.
You can also visit their website at www.ombudsman.org.uk.

Complaints about the use of the Mental Health Act can be investigated by CQC if it is from, or about, someone who has been:

- Detained in hospital
- Subject to a Community Treatment order
- Subject to guardianship

Phone CQC on: 03000 616161 – press ‘1’ to speak to the mental health team.

Independent health care

The term ‘independent health care’ means health care services run by private or voluntary organisations.
If you want to make a complaint about an independent health care service, you should contact the person or organisation that provides the service. By law, they must have a procedure for dealing efficiently with patients’ complaints.

The Independent Healthcare Advisory Services (IHAS) is an organisation that represents many independent health care services. It has a code of practice for its members on dealing with patients’ complaints. It also provides helpful information about how to complain on its website at www.independenthealthcare.org.uk.

Local authority complaints procedures

For services contracted by a local authority or for services provided by the local authority itself, it may be more appropriate to use the local authority’s complaints procedure. As a first step, people should try to settle a disagreement through an informal discussion, involving:

- the professionals involved.
- the person who may lack capacity to make the decision in question (with support if necessary)
- their carers
- any appropriate relatives

If the person making the complaint is not satisfied, the local authority will carry out a formal investigation using its complaints procedure. After this stage, if not resolved, a social service Complaints Review Panel can hear the case.

Other complaints about social care

People can take their complaint to the CQC if -

- the complaint is about regulations or national minimum standards not being met, and
- the complainants are not happy with the provider's own complaints procedure or the response to their complaint.

If a complaint is about a local authority's administration, it may be referred to the Commission for Local Administration.

Complaints about other welfare issues

The Independent Housing Ombudsman deals with complaints about registered social landlords in England. This applies mostly to housing associations. But it also applies to many landlords who manage homes that were formerly run by local authorities and some private landlords.
Complaints about local authorities may be referred to the Local Government Ombudsman. They look at complaints about decisions on council housing, social services, Housing Benefit and planning applications.

Adult Safeguarding Concerns

Any concerns about potential abuse of an adult with care and support needs should **always** be referred under the Local Authorities Multi-Agency Adult Safeguarding Policy. In some of these cases, the Office of the Public Guardian may be contacted.

Further reading

Mental Capacity Law and Policy

MCA Directory | SCIE

39 Essex Chambers | Updated Guide to Best Interests | 39 Essex Chambers | Barristers' Chambers

39 Essex Chambers | Mental Capacity Guidance Note: Assessment and Recording of Capacity| 39 Essex Chambers | Barristers' Chambers

Overview | Decision-making and mental capacity | Guidance | NICE