Welcome to Gloucestershire’s third Mental Capacity Act (MCA) and Safeguarding Adults Newsletter produced jointly by Mental Capacity Act Governance Group (MCAGG) and the Safeguarding Adults Board (SAB).

The aim is to provide quarterly news updates and information about local and national topics relating to Safeguarding Adults, the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). As you go through the Newsletter you will be able to gain additional information by clicking on the picture or hyperlink to the original report or news item.

The Newsletter has regular features such as Issues raised in Safeguarding and MCA. Training - this time focusing on decision makers and the need to be very clear about actual options available. There is also recent legal updates and relevant case law which in this edition includes Supreme Court ruling that changes the law on informed consent. Safeguarding looks at Carers Emergency Scheme, financial abuse and a quiz!

Gloucestershire offers different levels of training for Safeguarding and MCA/DoLS. This edition focuses on the Safeguarding Adults Training Pathway E-learning.

E-Learning packages: Safeguarding Adults; Mental Capacity; Deprivation of Liberty Safeguards; Safeguarding Leadership; Domestic Abuse; Safeguarding Children

For: All staff working in Health & Social Care, including reception, clerical and admin staff, Domestic and ancillary staff, Transport staff, Day service staff, Volunteers, Personal Assistants, Family Carers

How: Log on at www.kwango.com Select appropriate username and password, then select appropriate course Please see e-learning brochure for user names & passwords or email trainingenquiries@gloucestershire.gov.uk.

Meets induction standards and supports standard 10 of the new Care Certificate.
New Judgement on Patient Consent

Montgomery v Lanarkshire Health Board [2015] UKSC 11

Full judgement:-

[Link to full judgement]

This Supreme Court judgment is required reading for all medical professionals, because the Supreme Court has made clear that the doctrine of informed consent is now part of English (and Scottish) law.

Key points taken from 39 Essex Chambers


The issue arose in the context of whether a doctor was negligent in not informing a pregnant diabetic woman that there was a 9-10% risk of shoulder dystocia during vaginal delivery (the baby’s shoulders being too wide to pass through the mother’s pelvis). The doctor’s policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which was not in the maternal interest.

The justification for this change of approach will be obvious. A patient has her own right to make her own decision based upon sufficient information. A doctor must respect that right if there were material risks which a reasonably prudent patient would think were significant. Medical evidence would of course be relevant to that decision, but the decision was ultimately legal rather than one for the doctors. As the main judgment puts it at [75]…patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.

Times have moved on from the “doctor knows best” approach of Sidaway. There are so many other sources of information available to patients (the internet, patient support groups, drug labelling etc) and hence it would therefore be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors. The idea that patients were medically uninformed and incapable of understanding medical matters was always a questionable generalisation… To make it the default assumption on which the law is to be based is now manifestly untenable.

Comment

As regards the question of how clinicians are to engage in discussions with those of impaired capacity, 39 Essex Chambers suggest that:-

namely that they should understand the nature, purpose and effects of the proposed treatment, the last of these entailing an understanding of the benefits and risks of deciding to have or not to have the proposed treatment, or of not making a decision. Further, and crucially, as Peter Jackson J made clear, what is required is a broad, general understanding of the kind that is expected from the population at large;

2. What is required of the doctor is as set out in Montgomery, with a particular emphasis upon the injunction of Lords Kerr and Reed in Montgomery against bombarding the patient with technical information which she cannot reasonably be expected to understand. How the information is to be made comprehensible is self-evidently a task that must be calibrated to the patient in question. If not, the doctor will not be able to say that they have complied with the injunction in s.1(2) MCA 2005 to take all practicable steps to enable the person to take the decision.

http://www.bailii.org/ew/cases/EWHC/COP/2014/342.html

Law Commission on Mental Capacity and Deprivation of Liberty

The deprivation of liberty safeguards (“DoLS”) established an administrative process for authorising deprivations of liberty in a hospital or care home. In recent years, the DoLS system has been heavily criticised and increasingly viewed to be unfit for purpose. Furthermore, following the widening of the definition of deprivation of liberty in the Supreme Court decision of Cheshire west, an increase in the number of DoLS cases has left the regime struggling to cope.

On 7 July 2015 the Law Commission published its Consultation Paper on Mental Capacity and Deprivation of Liberty. The consultation paper considers how the law should regulate deprivations of liberty involving people who lack capacity to consent to their care and treatment arrangements. The consultation paper proposes that the DoLS should be replaced by a new system called “protective care”. It also proposes that there should be a new code of practice, and that the UK and Welsh Governments should also review the existing Mental Capacity Act Code of Practice.

The proposed protective care system will have a wider scope than DoLS; it will apply not only to hospitals and care homes but will extend to supported living and shared lives accommodation, as well as care and treatment offered in a domestic setting. The overarching system
of protective care will comprise of three different schemes specifically tailored to different care settings and the level of care / treatment being received.

There are other significant changes proposed including protective legal framework to adjudicate the Protective Care Scheme, key of which is the establishment of a First Tier Tribunal to review cases under the restrictive care and treatment scheme.

The consultation closes on 2 November 2015. Please see the link easy read, summary and full papers at Law Commission web site:


Please give feedback to the Law Commission’s proposals, using the link above.

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Legal Update

Deprivation of Liberty In Community Settings - Who Represents P?

In Re X and others (Deprivation of Liberty) [2014] EWCOP 25 (and No 2 [2014] EWCOP 37), Sir James Munby, the President of the Court of Protection sought to devise a streamlined process to seek to enable the court to deal with DoL cases in community settings in a timely, just, fair and ECHR-compatible way. In June 2015, the Court of Appeal held that Sir James Munby P had not been entitled to proceed in the fashion that he did, and that his ‘judgments’ were in fact not authoritative statements of the law.

Although the Court of Appeal held that it did not have jurisdiction to consider the appeals brought against the ‘decisions’ of the President, the members of the Court of Appeal made clear that both fundamental principles of domestic law and the requirements of the ECHR demand that P (the person being deprived of their liberty) be a party to proceedings for authorisation of deprivation of liberty.

Strictly speaking, the conclusions of the Court of Appeal are ‘obiter’ (in other words not binding), but it is anticipated that the Re X procedure set down in Practice Direction: 10AA: Deprivation of Liberty applications, is likely to be revised in short order to reflect these conclusions.

It may be that the Court will develop procedures that allow for the participation of P (for instance by the appointment of a representative) without making them a party. In order to square with the conclusions of the Court of Appeal, that participation will have to be automatic – i.e. not contingent upon P expressing a desire to participate.
This decision does not alter the obligation on local authorities to seek authorisation from the Court where such is necessary, nor does it alter the nature of the evidence that must be put before the Court – what it alters is what the Court must then do in order to ensure compliance with Article 5(1)(e) ECHR.

The difficulty in practice will be in arranging for P to be represented in cases before the court. If there are no family or friends willing to act as a litigation friend for P, how can cases proceed? If LA’s make applications to COP under the current guidelines the court will not be able to progress cases and a backlog of will be created. This would protect the LA’s from legal action for failing to bring cases to court but will not solve the problems. Cases will take even longer to complete and more uncertainty will be created for practitioners, service users and families. New guidance from COP is awaited with interest.

The Law Commissions proposals for changes to the deprivation of liberty regime would assist in resolving the current difficulties being experienced with seeking authorisations in community settings. They create a different set of issues which are out for consultation until November.


**Issue from Training**

**Decision Making and being clear about the options that are actually available.**

In MCA training, practitioners are constantly reviewing how to undertake a good capacity assessment and a key message is always be clear what about what decision is the person being asked to consider and what are the available options or choices for that decision. The case below, although looking at the jurisdiction of the Court of Protection, has highlighted how important this issue is, as should the person lack capacity, the Decision Maker will be bound to choose between the options that are actually available. **Essential reading for commissioners, managers and CHC leads.**

In the Matter of MN (Adult) [2015] EWCA Civ 411 (Court of Appeal) (Sir James Munby P, Treacy and Gloster LJJ)
Summary (taken from 39 Essex Chambers Mental Capacity Law Newsletter May 2015) (see link below)

The Case was concerning where a young man should live (and receive education and care), and for regulation of his contact with his parents and other family members, the relevant funding body, ACCG, had made it clear that it was not prepared to fund contact between P and his family at the parents’ home. ACCG therefore submitted that this was not an
option for the Court to consider when making best interests decisions; Counsel for the parents submitted that the Court should embark upon a trial in relation to home contact (and to the delivery of personal care by the man’s mother). The jurisdictional issue to which this gave rise – i.e. as to the precise scope of the Court of Protection’s powers – arose very late in the day, but it having been fully argued, Eleanor King J gave a full judgment upon the point. Eleanor King J held that the Court of Protection was – in essence – bound to choose between the options that were actually available.

1 There are some decisions where the person’s decision-making capacity is irrelevant. A stark example is the decision of a doctor not to offer a particular treatment to a person because they consider it is futile. This decision does not depend upon the person’s ability to consent or refuse it. Even if they demanded it they could not compel the doctor to provide it: see Aintree v James;

2 There are some decisions where the person’s capacity is vitally important and, if they lack the capacity, a best interests decision must be taken on their behalf. For instance, a decision must be taken about whether a person should go into care home A or care home B, either of which is available. They cannot decide and a decision must be taken on their behalf;

3 Most decisions regarding care and treatment are taken informally in reliance upon s.5 MCA 2005. This provides a defence to liability in respect of acts in connection with care or treatment where the person or body carrying out the care or treatment reasonably believes that the person lacks the capacity to take the decision and the steps taken are in their best interests; This was emphasised by Baker in G v E [2010] EWCOP 2512: “the vast majority of decisions are taken informally and collaboratively by individuals or groups of people consulting and working together;”

4 But it is vitally important to remember that the MCA 2005 only provides that a best interests decision is taken where the individual would take or participate in the taking of a decision.

5 This means that not all decisions taken by a public body about care provision – i.e. how to meet the assessed needs of the individual – are best interests decision. As Nicholas Paines QC the Deputy Judge said in R (Chatting) v (1) Viridian Housing (2) London Borough of Wandsworth [2012] EWHC 3595 (Admin) “the fact that Miss Chatting is mentally incapacitated does not import the test of ‘what is in her best interests?’ as the yardstick by which all care decisions are to be made” (a passage specifically endorsed by Sir James Munby P in ACCG);

6 That does not mean that such decisions are not to be taken without reference to the individual’s welfare or their views, but they are decisions which are, ultimately, decisions that are taken by the public bodies in discharge of their public law obligations, not decisions taken on behalf of the individual in question. They are therefore not best interests decisions, and (1) any meetings which are convened
to discuss them should not be labelled best interests meetings; and
(2) any challenge to them lies not in the Court of Protection but in the
Administrative Court.

None of the points set out above are – or should be – surprising, but
in and out of the court arena we do continue to find that confusion
creeps in, leading – where it is not checked – both to (inadvertently)
misleading conversations with families and in some cases to expensive
and misguided legislation. One particular area that we find where
this happens with considerable regularity is in relation to discharge
planning from hospital: it is absolutely vital that the relevant
statutory bodies are clear with themselves in advance of any
meeting with the patient/family members precisely which options
are on the table, and which (in proper discharge of their public
law functions) they are not prepared to fund.

http://www.39essex.com/content/wp-content/uploads/2015/05/MC-
Newsletter-May-2015-Compendium-Screen-Friendly.pdf

End of Life Care

Following the above article, it is worth considering the One Chance to Get
It Right

data/file/323188/One_chance_to_get_it_right.pdf

guidance on care-planning at the end of life and the very clear distinctions
drawn there between several types of conversations that clinicians may
have. In other words, is the conversation that the public body employee
would wish to have with the person whose capacity is in issue a
conversation to:

1 Inform them about a decision;
2 Consult them about a decision;
3 Involve them about a decision; or
4 Seek that they take that decision?
The first type of conversation can never lead to a best interests decision being taken where P lacks the capacity formally to engage in it; the second may not, even the third may (in some circumstances), and it is only in respect of the fourth type of conversation that it will be clear that a best interests decision will be made. Put another way, it is only if the decision-maker is standing in the shoes of P that we can properly say that a best interests decision is being made.

Where a person is unable to make decisions for themselves about end of life care and/or treatment, professionals are legally required to make decisions for the person in their ‘best interests’. When making best interests decisions, everything possible should be done to consider the person’s wishes and feelings both past and present, and to involve the person as much as possible. The professional must also take into consideration the views of family and others who are significant to the person as part of the best interests process.

Gloucestershire has Best Interests Decisions for End of Life Care Booklet which has been devised to be used where there are concerns about a person’s ability to make decisions about end of life care and/or treatment. The booklet can be used to demonstrate the assessment of the person’s capacity in this area of decision making, and where a person does not have capacity there is an opportunity to record the decisions that all agree are in the person’s best interests. As this document relates to medical decisions and the assessment of capacity the decision maker will be the GP.

http://www.gloucestershire.gov.uk/extra/CHttpHandler.ashx?id=60379&p=0
New Lasting Power of Attorney (LPA) Forms

How have the forms changed?

The changes to the forms reflect responses to the OPG’s consultation and feedback from users who were directly involved in their development. The OPG hopes that the redesign will make the forms easier to follow and faster to complete.

Under the new forms, the requirement for a second certificate provider has been removed. However, other safeguards remain the same, such as the need for an independent witness/es and someone certifying that the donor has capacity.

The OPG has advised that the new LPA forms complement the existing online LPA service, which takes users through each page of the application step-by-step, making sure it is completed correctly before it’s printed off and submitted. They have also improved the online service to better support solicitors’ processes.

A reminder that from 1 July 2015, there are new LPA forms for both property and affairs and welfare. The new forms are available on the Gov UK website.

https://www.gov.uk/search?q=LPA+forms

Property and affairs


Health and welfare


You can still use the old forms until 1 January 2016.

Mental Capacity Act A brief guide for providers of Shared Lives and other community services, part of the Winterbourne View Joint Improvement Programme
The Winterbourne View Joint Improvement Programme (JIP) was established to help local areas develop health and care services that enable people with learning disabilities and/or autism who have mental health conditions and/or behaviour that challenges to live locally in community-based settings.

Standards of care for people with learning disabilities and/or autism have received renewed public attention following a number of high profile cases, including those found at Winterbourne View hospital. The guidance was commissioned by the JIP in partnership with the Care Provider Alliance (CPA), to support providers in applying the Mental Capacity Act so that the legal rights of those who may lack capacity are upheld and that the individual is at the heart of decision-making.

While the work of the JIP is focused on people with learning disabilities and/or autism, the Act applies to a wider range of individuals. This guidance is therefore relevant to any provider of community services for individuals who may lack capacity. Link:

http://www.local.gov.uk/documents/10180/6869714/L14-393+MCA+guides_09.pdf/e95b1230-88b3-44dc-8cb9-4672c5d1ce3d

Mental Capacity Act 2005 An Easy Read Guide
Produced by the Local Government Association (LGA), Care Providers Alliance and NHS England

http://www.local.gov.uk/documents/10180/12137/ntal+Capacity+Act+2005+easy+read+guide/38683f88-4b96-49d6-86ab-89b2404d2e7a

Care improvement Works

Find reliable guides, learning tools and resources to support improvement against Care Quality Commission (CQC) inspection questions on a new online resource from SCIE and Skills for Care.

Care Improvement Works, developed with support from the Think Local Act Personal consortium, maps products to the CQC’s inspection questions and ‘key lines of enquiry’. Care providers can use the online resource before and after inspection, or at any time to identify products that support improvement in areas where they may have concerns, or to review their current practice against recognised good practice. People who use services, and carers, can also use the products to challenge their care providers.

More information is available at

www.careimprovementworks.org.uk
Mental wellbeing of older people in care homes

This NICE resource is for managers of care homes for older people, including residential and nursing accommodation, day care and respite care. It will help managers put NICE’s quality standard defining best practice in mental wellbeing of older people in care homes into practice. It highlights key messages for care providers for each of the 6 quality statements that make up the standard.

https://www.nice.org.uk/about/nice-communities/social-care/tailored-resources/mwop

Consultation open on new social care topics for NICE

Safeguarding in care homes, adoption in looked after children and young people, and support for carers are among social care topics being considered for new NICE guidance and quality standards. The consultation closes on Friday 9 October 2015. For full details, and to take part in the consultation, visit the social care section of their website.

Carers Emergency Scheme

Does someone depend on you – do you worry about what would happen to the person you are looking after, if you were taken ill or caught in some kind of emergency? If you answer is YES then this scheme may be for you.

For your peace of mind call Carersline on 0300 111 9000 for more information.

Financial Abuse

Financial abuse is thought to be the second most common form of abuse after neglect. According to Action on Elder Abuse, there has been a 150% increase in reports of financial abuse to the charity’s helpline in the last year.

There is every reason to suppose that the threat posed to older people is increasing. For example, the numbers living with dementia and cognitive...
decline are significant and growing and some fraudsters conscientiously search such people out in order to part them from their money. In addition, the internet opens up new possibilities for fraud and as more older people go online, so the numbers potentially at risk of being defrauded also rise.

Remember...
• if it sounds too good to be true it probably is
• if you haven’t bought a ticket – you cannot win it
• if in doubt, don’t reply – bin it, delete it or hang up
• you shouldn’t have to pay anything to get a prize
• contacted out of the blue? Be suspicious
• never give out your bank details unless you are certain who the person is
• financial providers do not ask for your pin number, so do not give it or any other personal details
• take your time and resist the pressure to make a quick decision.

Social isolation and loneliness

Research into this area is showing that this not just an emotional experience, it can have a harmful impact on health. It has shown that it increases the risk of cognitive decline and more prone to depression. One study showed a 64% increased chance of developing clinical dementia (Holwerda et al, 2012). All these could lead to a person becoming more vulnerable to harm and abuse. The Local Government Association have some guidance and videos which you can view through the following link:

http://www.local.gov.uk/ageing-well/what-makes/-/journal_content/56/10180/3489443/ARTICLE
Introducing Silver Line

The Silver Line is the only free confidential helpline providing information, friendship and advice to older people, open 24 hours a day, every day of the year.

More than half of all 75 year olds in the UK live alone and one in ten suffers intense loneliness but is reluctant to ask for help. In a poll conducted to mark the national launch of The Silver Line on 25 November 2013, 9 out of 10 older people told researchers that “a chat on the phone” is the most helpful solution when they feel lonely but 1 in 4 older people say they never or seldom have someone to chat to on the phone.

The Silver Line is the confidential, free helpline for older people across the UK open every day and night of the year. The specially trained helpline staff:

• Offer information, friendship and advice
• Link callers to local groups and services
• Offer regular befriending calls
• Protect and support those who are suffering abuse and neglect

The Silver Line is a helpline for older people. There are no strict age limits but most people that Silverline speak to are over 65. So, if you think it’s for you, it’s for you.

Silver Line can be contacted on 020 7224 2020 or email: info@thesilverline.org.uk

More information is available at www.thesilverline.org.uk

Stop the Traffik campaign around Human Trafficking and the Modern Slavery Bill

Over the last three years more than 1,000 men, women and children were identified as potential victims of labour trafficking in the UK. In 2012 that figure increased by 11 per cent and is predicted to continue to rise. Stop the Traffik encourages action around the inclusion of supply chains legislation in Modern Slavery Bill:

More information is available at http://www.stopthetraffik.org/gb/modernslaverybill

Crimestoppers UK are asking the public to watch and share their Human Trafficking video – ‘Read the Signs’

https://crimestoppers-uk.org/
Gloucestershire Safeguarding Adults Annual Report
2014/15

Paul Yeatman, Independent Chair of the Safeguarding Adults Board, is pleased to announce the publication of the Annual Report, together with a short summary document. The Annual Report has been shaped by last years feedback and hopefully you will find that it is both comprehensive and not too lengthy. During the past 12 months the board has developed it strategy plan into a 3 year plan, with its objectives embracing the principles of Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability. To view the full report or the summary click on the link GSAB Annual Report

http://www.gloucestershire.gov.uk/gsab/CHttpHandler.ashx?id=64046&p=0

Safeguarding Adults
and Mental Capacity Act
Newsletter

In all our Newsletters we hope to dedicate our final section to providing useful information for people who use Health and Social Care Services and their families.

As this Newsletter is focused on providing people with information on Adult Safeguarding and the Mental Capacity Act, we thought it would be useful to offer links to some resources that clearly explain what these areas of Policy and Government Legislation are all about.

For local information about Adult Safeguarding in Gloucestershire you can visit our website by clicking here on the link

www.gloucestershire.gov.uk/gsab

This main page has sections with all the information you need to understand Adult Safeguarding, and also has the numbers to call should you expect that a adult you know or care for is being abused.

There are many other resources out there that also explain how you can make sure you are keeping your relative or loved one safe.

www.gloucestershire.gov.uk/gsab/CHttpHandler.ashx?id=47742&p=0

The Safeguarding Adults Board wish for the content and future development of the Safeguarding Adults and Mental Capacity Act Newsletter to be led by the views and voices of Safeguarding Practitioners, Health and Social Care Professionals, Provider Services, the voluntary and community sector and people who use services and their families.

So if you have information or work you wish to share, ideas for future articles, suggestions for improving the newsletter or questions you wish to pose you can do this by emailing: rhiannon.mainwaring@gloucestershire.gov.uk

We would also ask that all professionals and providers share this Newsletter with all the people and families they support.

Information on Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards training can be found via this link

www.gloucestershire.gov.uk/gsab/CHttpHandler.ashx?id=47742&p=0

The newsletter in produced jointly by Rhiannon Mainwaring, MCA Governance Manager and Ann Gribble, GSAB Business and Project Officer. In this edition we would like to give thanks to Simon Thomason for his contribution.