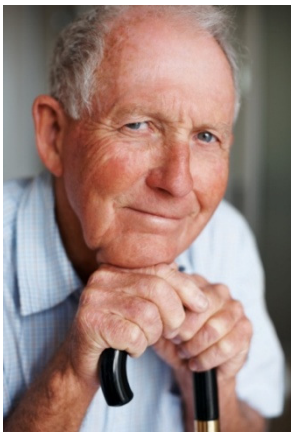
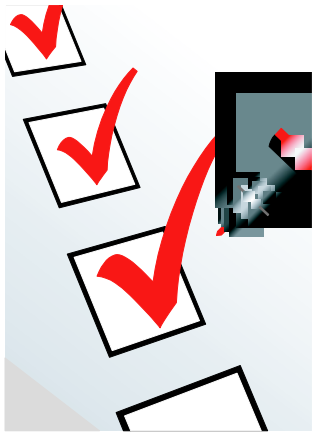
IMCA INSTRUCTION

BEST PRACTICE GUIDANCE





action for advocacy

IMCA Support Project

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Preface

When the IMCA support project first started in August 2009, we ran an online survey which asked IMCAs and their managers what priority areas the project should focus on in the first year. This included asking what issues IMCA providers currently face, what support and resources we could offer. We also asked some key questions about how providers responded to different factors at the initial stage of IMCA instruction, report writing and aspects of the MCA 2005 Code of Practice. A wide range of responses were received, including concern about the variance in IMCA practice which has emerged over the past three years and the need for practice guidance in a number of areas.

After analysing the survey feedback, discussion with IMCAs at network meetings and with individual IMCA providers, we decided to firstly write best practice guidance that focuses on the beginning and the end of the IMCA process and have therefore produced best practice guidance on instruction and report writing. This guidance aims to offer a suggested way forward to ensure that the statutory service being delivered offers quality and consistency.

An advisory group was formed which consisted of a wide range of IMCA providers. We would like to thank participants for their input, which contributed significantly to the content of this guidance.

Jakki Cowley **Sue Lee**

IMCA Support Project Managers

July 2010

Endorsement by the

Association of Directors of Adult Social Services

The Association of Directors of Adult Social Services (ADASS) is the national organisation in England and Northern Ireland representing directors of social care in local social services authorities. ADASS members are responsible for providing or commissioning, through the activities of their departments, the well-being, protection and care of hundreds of thousands of people, as well as for the promotion of their well-being and protection wherever it is needed. Close formal and informal links are maintained with the NHS and with central government in helping to shape and implement policy and social care legislation.

Within ADASS the work on supporting the implementation of the Mental Capacity Act 2005, including the additional Deprivation of Liberty Safeguards, is located within our Mental Health Drugs and Alcohol Network. Greg Slay (West Sussex County Council) has been our lead officer in this work since 2005, recently and ably assisted by Lindsay Smith (Halton Council) and Richard Smith (Telford and Wrekin Council).

We are pleased to work in partnership with Action for Advocacy, the Social Care Institute for Excellence, and many other organisations in improving practitioner awareness of the Mental Capacity Act 2005.

We commend this IMCA guidance to IMCA Service advocates and managers and hope it will be well used – it deserves to be!

We also commend this IMCA guidance as a reference document to commissioners of statutory advocacy services as well as those staff who have a legal duty to refer to the IMCA Service in their local areas.

Richard Webb (Sheffield Council) **Jonathan Phillips** (Calderdale Council)

Co-chairs, ADASS Mental Health Drugs and Alcohol Network

July 2010

Introduction

It is evident that whilst the IMCA service is a statutory one, individual IMCAs come from diverse and varied backgrounds. Some have a wealth of advocacy experience, for example, in mental health, learning difficulties, working with older people or another aspect of social care. Other IMCAs may have a social work, nursing, health or legal background resulting in a workforce which is varied in professional experience and is quite unlike many other sectors. Each IMCA accesses initial training and then undertakes the demanding and at times challenging role. It is inevitable that in this new area of work, interpretation of the role and the legislation within which people are working will mean that IMCAs will practice differently.

Many IMCA providers share the concern that inconsistencies in practice are not desirable for a new profession. Inconsistency can make it difficult to establish credibility amongst other professionals and that referrers to the IMCA service may experience differences in approach, depending on which IMCA service they instruct. It is therefore important that the IMCA profession makes some decisions around best practice for IMCA instruction.

There are a number of key questions which the instruction best practice guidance addresses:

- What constitutes a legal instruction?
- What barriers might exist which hinder timely instruction?
- Can IMCA services refuse to get involved once instructed?
- What is the role of the written capacity assessment in IMCA instruction?
- How can we clarify the 'appropriate to consult' criterion?

There is concern that many people who lack capacity to make a decision about serious medical treatment are denied their right to the support and representation of an IMCA. The NHS is made up of large and often complex organisations and many IMCA providers have found it difficult to engage with their local Acute Trusts. Gaining instructions for SMT decisions has proved challenging in some areas despite IMCA providers' best endeavours to promote their services and to raise awareness of clinicians' responsibilities under the Act.

The guidance suggests that identifying a range of professionals who may instruct, for example, taking instruction from someone who isn't the responsible consultant, may result in more SMT referrals.

Some of our contacts working within the NHS have suggested that some IMCA instruction/referral forms are too long and that this is a potential barrier to instruction. So with that in mind, we devised a template form which organisations can adapt for their own use.

IMCA Instruction Best Practice Guide

What's covered in this guidance?

This guidance will cover the instruction process for Independent Mental Capacity Advocates including what constitutes a legal instruction, who is 'appropriate to consult' and the role of the capacity assessment in the instruction process. It will clarify information in the Code of Practice which has been interpreted variously by IMCA providers and identify good practice in relation to IMCA instruction. It also includes an example instruction form template.

Instruction for DOLS will be covered in separate guidance.

Good practice in IMCA instruction is achieved where:

- IMCA instruction forms are short and easy to complete
- IMCA providers react to instructions in a timely manner
- Professionals working within decision making bodies are fully aware of the eligibility criteria for IMCA
- The instruction process is accessible to potential instructors

The legal process for instruction (referral)

The Mental Capacity Act (2005) and Regulations say that an IMCA must be instructed by the responsible body in situations where a decision about a change of accommodation or serious medical treatment is being made on behalf of a person who lacks capacity. These regulations set out the circumstances in which the IMCA must be appointed. The Expansion Regulations give responsible bodies the power to instruct an IMCA for two further types of decisions: a care review and adult safeguarding but not all IMCA services may have been commissioned to provide a service in these situations.

IMCAs must be instructed by an authorised person in order to support and represent a person who lacks the capacity to make a particular decision. Without instruction, from an authorised person (referrer) , IMCAs have no authority to carry out their role. The IMCA has a responsibility to ensure that the person instructing them has the authority to do so:

'..the IMCA must (a) verify that instructions were issued by an authorised person[1]*'*

[1] (6(4)(a) The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006)

IMCAs will want to check that the instruction (referral) states that it is:

- for a decision where there is a duty or a power to involve an IMCA
- for a person who lacks capacity to make the specific decision
- for a person who does not have family, friends, an attorney or any other named person who is available, willing and appropriate to be consulted about the decision

When the decision relates to safeguarding, an IMCA can be instructed even if there are family and/or friends who are considered 'appropriate to consult'.

It does not state in the Act that IMCAs must receive a written instruction. Good practice is that an instruction (referral) form is completed, but this should not be used as a barrier to responding swiftly to instruction. If an instruction has been made by a person who is authorised/enabled to make an instruction, the IMCA service must respond to that instruction.

This written instruction provides evidence (should it be needed) that the IMCA was formally instructed by a person who has the authority to do so. It should also evidence that the person is eligible for IMCA; the decision is one prescribed by the Act, that there is nobody appropriate to be consulted and that the person lacks capacity to make the proposed decision. The IMCA service is intended as a safeguard for people who have nobody who is considered appropriate to be consulted about the proposed decision. Therefore if there is

- family and/or friends who are considered 'appropriate to consult'
- a person who has been previously named by the person when they had capacity as someone who should be consulted
- an attorney under an LPA, or a deputy who has been appointed by the court who has the relevant authority to make a decision on behalf of the person who lacks capacity

then there is no duty to instruct an IMCA.

Who can be an 'authorised' person?

Regulations (The Mental Capacity Act 2005(Independent Mental Capacity Advocates) (General) Regulations 2006) define an authorised person as a person who is *'required or enabled to instruct an IMCA.'* An authorised person within the NHS, for example, could be a consultant, a nurse or a ward sister. Responsible bodies can also authorise other bodies or organisations to instruct an IMCA.

Instruction for a change of accommodation decision

When a change of accommodation decision is being made, the professional instructing the IMCA is most likely to be the social worker or care manager working for the local authority or hospital who will be making the best interests decision. It could be another person who is enabled/authorised by the decision making body.

Instructing an IMCA for a change of accommodation decision for a person detained under the Mental Health Act 1983

IMCAs must be involved when residential care is provided or arranged by the local authority or provided under section 117 of the Mental Health Act 1983 or there is a move between such accommodation (chapter 10.51, Code of Practice).

Instruction for a Serious Medical Treatment decision

Gaining instruction for serious medical treatment decisions has presented some challenges. Some providers have received very few instructions for serious medical treatment decisions since the start of the service. The reasons for this are complex and varied, however, IMCA providers should consider if there are any barriers which may contribute to NHS organisations not referring. A more flexible approach regarding who can instruct for Serious Medical Treatment decisions within the decision making body may mean that more vulnerable people are afforded the IMCA safeguard.

The Code of Practice has generally been interpreted to mean that the person actually responsible for making the best interests decision is the person who should instruct the IMCA and therefore, as consultants are likely to be decision makers for SMT, IMCAs believe it is the responsible consultant who must instruct. The Act does not impose the duty to instruct on any specific role and so it will be for each NHS organisation to decide who within the organisation can instruct.

Working out who is responsible for making the instruction when there are a number of different health professionals involved in diagnosing or providing treatment can be challenging. Ultimately, the instruction for an SMT decision needs to be made by *'the NHS organisation providing the person's healthcare or treatment*[2]*'*.

IMCA services should work with NHS bodies to identify which particular groups of professionals could instruct. This will then reduce the risk of delay to the IMCA starting the work as instruction is not reliant on any one person being available. Trying to get instruction from a particular doctor, who has been described by the hospital as the person responsible for making the decision, can sometimes prove difficult in large organisations and if another authorised professional within the hospital is able to instruct, the IMCA's work could start at an earlier stage.

Some IMCA providers have worked with NHS bodies to identify doctors, nurses, psychiatrists, occupational and other therapists and learning disability specialists as authorised persons. These have been written in protocols and agreed by both parties.

IMCA providers should work with their local NHS Trust to encourage them to determine a wide range of health professionals who can instruct IMCA. This could include, for example, ward sisters, consultants and consultants' secretaries.

Which organisation instructs the IMCA for a patient who is referred to a hospital from another area?

There isn't the same clarity as there is for a change of accommodation decision where the person lives in a different area to where the decision maker is based. As a rule of thumb however if a person is receiving treatment as an inpatient the IMCA service to be instructed is the one based in the same area as the hospital.

Where a client has an outpatient appointment or their treatment is being provided in a regional unit which provides healthcare and treatment to patients who live in different areas of the country as a rule of thumb the IMCA service to be instructed will be where that person ordinarily resides. This can then ensure the person is placed at the heart of the decision making process e.g. the IMCA in their locality can easily meet with the

[2] *MCA Code of Practice 10.9.*

person and have their discussions with the decisions maker via email or on the phone, or depending on the location of the out patients appointment it may be feasible for the IMCA to travel there also.

In terms of responsibility for instruction the medical practitioner who decided that the person should attend the regional unit should instruct an IMCA where the person ordinarily lives. There may need to be some flexibility around this and ultimately the right service is the one which is best able to provide direct support to the client.

Occasionally there will be IMCA involvement before the person goes to another part of the country for a stay in hospital. Perhaps the IMCA has been involved for several months and has got to know the person, their condition and their situation very well. Information relating to the decision should be shared between the IMCA services in the best interests of the client when a client is moving from one area to another and a decision made as to which service can support and represent the person most effectively. This may mean jointly working with the client if they are moving between hospitals.

Instructing an IMCA for a serious medical treatment decision when the person is detained under the Mental Health Act 1983

If a person lacks capacity to consent to serious medical treatment and there is nobody who is willing and able to be consulted, an IMCA must be instructed for the detained person unless their treatment is covered by the Mental Health Act 1983.

Should only the decision maker instruct?

There is nothing in the Act which states that only the decision-maker can legally instruct the IMCA. The person instructing must be authorised/enabled by the particular decision making body responsible for making the best interests decision and authorised by that body. *"Authorised person" means a person who is required or enabled to instruct an IMCA under sections 37 to 39 of the Act or under regulations made by virtue of section 41 of the Act."* 6(2) The Mental Capacity Act (2005) (Independent Mental Capacity Advocates) (General) Regulations 2006.

In many situations the decision maker and the professional making the IMCA instruction will be the same person. However, it is feasible, for example, that a

nurse or a consultant psychiatrist may instruct and the person responsible for making the decision will be a medical consultant. In practice, it means that there should be protocols in place between IMCA providers and the decision making bodies, the local authority and NHS Trusts, which set out who can make IMCA instructions in their respective organisations.

Whoever is instructing the IMCA the basic principles of instruction still apply, i.e. that they believe the referred person lacks capacity to make the specific decision, there is nobody appropriate to consult and the proposed decision is one where IMCAs can get involved.

If the person instructing is not the decision maker, IMCAs will of course want to identify who the actual decision maker is at an early stage in the case to start a dialogue, to commence partnership working and to make sure that the decision maker is aware of their responsibilities in relation to the IMCA role.

What if the IMCA service is alerted to a potentially eligible person?

Occasionally a person not authorised or enabled by the decision making body may have information about a person they believe to be eligible. For example, a manager from a residential care home (if not working for the Local Authority or NHS) or a generic advocate. Whilst they cannot instruct an IMCA they could of course contact the IMCA service and share the relevant information about the need for IMCA involvement. In this situation, as there may be a risk that a person who has a right to an IMCA may not receive their entitlement to IMCA support, good practice would be that the IMCA provider contact the decision maker i.e. social worker or relevant consultant within the responsible body directly to clarify if the client and decision meet the eligibility criteria.

Should the instruction (referral) form be signed?

There is no legal requirement for the person who is instructing the IMCA to sign the instruction form. Where a written instruction form is submitted, the responsible body is confirming that the person meets the eligibility criteria and they are authorised/enabled to give instruction.

Can an IMCA start the work without written instruction?

The Act does not state that written instruction is essential. The only legal requirement is that the person is authorised/enabled to instruct. Good practice is that the instruction is in writing as this provides evidence that the IMCA has been instructed to carry out the role should their involvement be questioned. However, there may be situations where the IMCA will consider starting the work without written instruction, for example, in a situation where a quick (not emergency – this can be made in the best interests of the patient without IMCA involvement) serious medical treatment decision is to be made the IMCA may consider going to the hospital with a verbal instruction and get written instruction later.

Can an IMCA service refuse to accept an IMCA instruction?

An IMCA service does not have a right to refuse an IMCA instruction. If the IMCA service believes at the point of instruction that the client may not be eligible for the service this should be discussed with the professional instructing IMCA, highlighting the need for the eligibility criteria to be met. This may at this stage result in the withdrawal of instruction by the instructor.

Once an IMCA instruction has been made by a person who is authorised/enabled to make an instruction, the IMCA service must respond to that instruction unless, after discussion about eligibility criteria, the instruction is withdrawn.

If an IMCA provider were to refuse an instruction they are effectively making a decision about whether the person has capacity and/or whether the family is appropriate to consult. If at some point in the future, questions are asked, perhaps in Court, about why a person did not have IMCA involvement, the responsible body would say that the IMCA provider made the decision that the person was not eligible **This would leave the IMCA provider open to legal challenge.**

Occasionally, there may be a difference in opinion between the instructor and the IMCA provider about whether the person is eligible or not for the statutory IMCA safeguard. If, after discussion about eligibility criteria, the instructor still believes that the person is eligible and would benefit from IMCA input, the IMCA provider cannot refuse the instruction because that would put them in a position of deciding whether or not the person has an IMCA which is not their role.

What if the IMCA starts work and it becomes clear that the person is not eligible?

Discussion with the instructor may lead to the instruction being withdrawn. IMCAs will want to suggest other advocacy services which may be appropriate for the referred person's situation. If the instructor still believes that the person is eligible for IMCA and does not feel that withdrawal of the instruction is appropriate, IMCA involvement must continue for the reasons outlined above.

If there is clear evidence that the person does not fulfil the eligibility criteria for IMCA services, the IMCA provider may want to raise the issue with their IMCA steering group or MCA group.

What if the IMCA believes the person may have capacity to make the decision?

The IMCA will want to request that another capacity assessment is carried out and if that demonstrates that the person does have capacity, the IMCA will want to discuss withdrawal of instruction. The IMCA ***cannot*** withdraw from the case on the basis that they believe the person has capacity and therefore has a right to make the decision for themselves ***unless*** the person instructing the IMCA provides evidence that the person has capacity and as a result they are withdrawing the IMCA instruction.

If IMCA instruction is not withdrawn by the instructor, the evidence which suggests that the person has capacity should be included in the IMCA's report and must be taken into account by the decision maker. The IMCA would want to include a statement about the person's right to make the decision for themselves and that the best interests decision making process is not appropriate. If any issues are not resolved by informal means, the IMCA may want to consider taking further action such as using appropriate complaint procedures to ensure the rights of the person with capacity are respected. Further information on capacity assessment and instruction is given on page 21 of this guidance.

What if the decision maker says that the client is not eligible?

Given that it will not always be the decision maker who instructs the IMCA service it is possible for there to be disagreement about eligibility between the person responsible for making the decision and the person who made the initial instruction. Examples of this are that the decision maker says there is no identified decision; they believe the person has capacity or they believe family/friends to be appropriate to consult.

It is possible that due to a lack of communication or information being offered or knowledge of the client and their circumstances, that genuine mistakes are made in terms of an initial referral. This should be identified as soon as possible when a disagreement between parties becomes apparent.

However if it is clear that the factors are the same but the professionals involved disagree about their impact or importance e.g. interpreting of information, different experiences of family involvement, emphasis on one aspect of the decision making process more than another then it is important that the IMCA communicates with the decision maker to request that the decision maker and instructor (referrer) come to an agreement about the eligibility of the client. It is important to highlight that it is not for the IMCA to resolve the disagreement by way of mediation but to explain that they have received a legal instruction and as such are required to fulfil their role

If the IMCA is instructed by a person who is authorised to do so, and the instructor believes that the person is eligible, the IMCA must progress the case.

If the decision maker does not engage with the IMCA, this should be recorded in the report. If the decision maker does not take into account information contained within the IMCA report when making the best interests decision, the IMCA may wish to progress this through either the relevant complaints procedures, a safeguarding adult alert or to seek legal advice.

Further options either at the start of the process (initial instruction) or at the end (after the decision is made) may be for the IMCA provider/manager to contact:

- The relevant professional's manager to seek guidance in terms of progressing the case.
- Discuss with the local MCA or LIN group.
- Contact the relevant responsible body legal department for guidance or so as to raise a concern about the process, adherence to the Act, policies/procedures (whichever is relevant).

Can a GP instruct an IMCA?

Early instruction to IMCA for serious medical treatment decisions is essential. Many IMCA providers report that often instruction is given late and decisions will be imminent giving the IMCA very little time to carry out their investigations or in some cases important treatment decisions have already been made. This needs to be addressed and IMCA providers, NHS Trusts and Primary Care Trusts should give serious consideration to approaches which result in timely instructions.

GPs have a vital role to play in ensuring that timely instructions are made as they will refer patients to specialist services and, where appropriate, an IMCA can become involved at an early stage. GPs generally work for Primary Care Trusts, not the same responsible body as the one likely to provide secondary care, i.e. the NHS Trusts. However, it is absolutely feasible that GPs **could be authorised/enabled** by the NHS Trust to instruct IMCAs for eligible patients seen by GPs or that GPs are in fact making decisions about serious medical treatment. An example is a woman who went to the GP because a mole on her arm had changed colour. The GP made a decision to remove the mole and sent it away for analysis. The test result showed that the mole was cancerous and a referral to specialist oncology services was made.

GPs also regularly make decisions about whether or not a person will be referred to specialist services for further investigations. For example, a person with a learning disability whose symptoms indicate that he may have bowel cancer and the GP is making a decision whether or not to refer the person to hospital, their decision may ultimately have serious consequences for the person.

Which IMCA service when the decision maker is based in a different geographical area?

An example is when a person's accommodation is funded from one local authority but the person is in a different area. The IMCA service where the person actually is, is the one which must be instructed and the instruction will come from the funding area.

What does 'appropriate to consult' actually mean?

The IMCA safeguard is primarily intended for people who do not have family or friends who can be consulted about the decision. The exception to this is for instruction in relation to safeguarding where a person can have involved family and friends and it is considered beneficial for the client by the responsible body to involve an IMCA.

There is some tension between the obligations of the decision-making body to find out the views of other people who are close to the person who lacks capacity and the need for them to consider if family or friends are 'appropriate to consult' when considering whether or not to instruct an IMCA.

When an IMCA is instructed and there are family or friends who know the person who lacks capacity, the instructor is acknowledging that an IMCA is needed, despite the fact that there are family or friends. It does not necessarily mean these people will be excluded from the decision making process or that their views will not be sought by the IMCA.

The Code of Practice (10.77) suggests some situations where there are family or friends but it may not be possible, practical or appropriate to consult with them. It is not possible to provide a definitive list of situations where family or friends would be considered not 'appropriate to consult.' However if there is a family member or friend (someone who is not paid to provide care or support) professionals will want to consider if:

- They have an insight into the person's views, wishes, feelings and beliefs in relation to the decision through knowing the person well enough to be able to provide this information
- They can be contacted by some means
- They are willing to be consulted
- There is any concern about the person's ability or willingness to faithfully represent the person's views
- There is any apparent conflict of interest (perhaps the family member/friend will be concerned about the impact of the decision on themselves, for example, if they will benefit from the sale of a house or if they live in a house which will need to be sold to pay care fees and it is therefore beneficial to involve a independent person)

- There are concerns, allegations or proven instances of abuse (any concerns should have already triggered a safeguarding alert and a safeguarding case may run alongside an accommodation/SMT decision)
- There are concerns about them acting in the person's best interests (perhaps the family/member or friend finds it difficult to separate best interests of the person from their own self interests)

If there are concerns about any of the above criteria then it's good practice that the professional considering IMCA will instruct. **Ultimately it is for whoever is instructing the IMCA to decide *in each particular case* if family members or friends are 'appropriate to consult' and whether an IMCA is needed.** The relevant factors will need to be considered on a case by case basis. Involving IMCA does not necessarily mean that family or friends will be cut out of the process. The professional who has instructed the IMCA and has deemed family or friends not 'appropriate to consult' is making a decision that although there are people around who know the person, there are good reasons to involve an IMCA and instruction is appropriate for that particular set of circumstances.

It would not be appropriate for family or friends to be judged not to be 'appropriate to consult' simply on the basis that they are not in agreement with the proposed best interests decision or because there is some conflict between family or friends and the decision maker.

> ***'If a family disagrees with a decision-maker's proposed action, this is not grounds for concluding there is nobody whose views are relevant to the decision[3]'***

Reasons for the family and/or friends not being considered 'appropriate to consult' should be given by the responsible body. IMCAs will also want to ascertain from whoever is instructing them that the family and/or friends have definitely been informed of the IMCA's involvement. The onus is on the responsible body to inform the family and/or friends and it is not the IMCA's role to do this. It is good practice to request that the decision maker documents why they believe family and/or friends are not appropriate to consult. This can be in the form of an email or recorded on the instruction form.

[3] MCA Code of Practice 10.79

What if the IMCA starts work and family then become involved?

In the first instance, the IMCA should ensure that the decision maker is aware of the family or friends. The instructor may at that stage wish to withdraw instruction if it is believed that they are 'appropriate to consult'. Other advocacy providers may be suggested by the IMCA as an alternative.

If, however the instruction is not withdrawn and the family are therefore considered not 'appropriate to consult' then the IMCA must continue with their work. If the IMCA has evidence that the family or friends are 'appropriate to consult' they may want to highlight any issues in relation to the instruction in their report or raise issues at the IMCA steering group or MCA group. It is not the IMCA's role to decide whether or not to withdraw from the case and if they did so on the basis that they had decided family or friends are appropriate. **This is unlawful and the IMCA could later be asked to justify their decision**.

It is important to highlight that an IMCA's involvement must reflect the criteria of the Act, which is clear that if there are family or friends who are appropriate and willing to be consulted, there is no requirement to instruct IMCA. **IMCAs cannot be involved in a mediation role when there are disagreements between family and the decision maker**. The MCA Code of Practice (5.62 – 5.69) offers further guidance for decision makers on this issue.

Should an IMCA consult with a family member or friend if they have been deemed 'inappropriate to consult'?

The MCA Code of Practice (10.20) places an obligation on IMCAs to *'get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity'.* There will be times when the IMCA will judge that it is appropriate to contact a family member or friend when they have been deemed not 'appropriate to consult' because that person may still have information pertinent to the decision being made.

IMCAs may want to consider consulting with the decision maker or other appropriate professional before approaching family or friends who have been deemed not 'appropriate to consult' in case there are any issues as yet unknown to the IMCA, although ultimately the IMCA does not need the consent from anyone in the responsible body before communicating with the person's family or friends.

There will be exceptions, for example, if the family member or friend is an alleged or proven perpetrator of abuse then serious consideration will need to be given as to whether it is at all appropriate to contact them. Further guidance about this is given in SCIE's 'Practice guidance on the involvement of IMCAs in safeguarding'.

Which area should instruct for Safeguarding cases?

If the alleged abuse happened in Cornwall, for example, but the person has returned home to live in Derbyshire, then the abuse will be investigated in Cornwall but the IMCA service to be instructed will be the one in Derbyshire. There are some exceptions, for example financial abuse by a family member could be investigated by either local authority.

Capacity Assessments and Instruction

Is there a requirement for the IMCA to see the written capacity assessment before starting the work?

Responsible bodies have to reasonably believe that the person lacks capacity based on the two stage capacity assessment defined in the Act. They should also work to the principle that every person should be assumed to have capacity unless it is proved otherwise. To fulfil the eligibility requirement of instruction to IMCA, responsible bodies must be able to evidence their reasons for believing that the person lacks capacity to make the specific decision being considered.

> ***'Ultimately it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed[4]'***

It is helpful if IMCA instruction is accompanied by a written capacity assessment where this has been undertaken but this is not required by the Act and IMCAs can start the work before seeing the capacity assessment. IMCAs should not wait for a copy of the written assessment of capacity after instruction has been received if it will result in a delay in the start of their work. Such a delay may mean that the decision making process carries on in their absence, unguided by the IMCA's report.

> ***'The responsible body: must, in all circumstances when an IMCA is instructed, take properly into account the information that the IMCA provides[5]'.***

A vulnerable person is therefore left without support and representation and the impact of the delay could have significant consequences for the person. For example, if there is a situation where a discharge from hospital is complex and the person is likely to be moved to a different hospital or other accommodation within a few days of instruction or a serious medical treatment decision that has to be made within a few days.

If instruction is received without the written capacity assessment, it is good practice for the IMCA to ask how the decision maker knows that the person lacks capacity to

[4] *MCA Code of Practice 4.40.*
[5] *' MCA Code of Practice 10.13*

make the proposed decision and to ask what support has been given to the person to enable them to make the decision for themselves. A discussion will clarify if assessment has in fact been carried out or whether assessment has not been attempted. Good practice would be to ensure that instruction forms include a question which asks the instructor to confirm that the person lacks capacity to make the specific decision in question. The IMCA should not delay involvement because they do not have a copy of a written capacity assessment.

If at any point in the case, the IMCA has concerns that the person in fact has capacity to make the decision they should request a copy of the most recent capacity assessment. If the IMCA believes that the assessment was not carried out satisfactorily, the IMCA can request that another assessment is carried out.

It is not within the scope of the IMCA's role to decide that a person has capacity to make a decision about their treatment or care and withdraw from the case on the basis that they believe the person has capacity. The correct process would be to challenge rather than withdraw. Ultimately an IMCA could support a person to challenge the mental capacity assessment which would be entirely appropriate and within the remit of their role. The Mental Capacity Act (2005) states that IMCAs can challenge decisions which includes 'a decision affecting P (including a decision as to his capacity).'

A report must be written which details the work (even if limited) the IMCA has done and raises any concerns. A report in this context may mean an email or some form of written statement as it may not be necessary or appropriate to complete a full report on the organisation's standard report template. The IMCA will want to point out that a person who has capacity has the right to make the decision for themselves, that the best interests decision making process is not appropriate and is an abuse of the person's rights. If this is the case, it will be beneficial for the person if there is a record of that and also any actions that the IMCA undertook. Information about challenges to a finding of lack of capacity is given in the MCA code of practice paragraph 4.63. Ultimately if a disagreement cannot be resolved, IMCAs can apply for permission to go to the Court of Protection. The Court of Protection can 'make a declaration as to whether a person has capacity to make a particular decision[6]'

[6] *MCA Code of Practice para 8.15*

Is a separate instruction needed for a care review following a change of accommodation case?

Instruction for a care review is a separate decision to instruction for a change of accommodation and should therefore be treated separately. The appropriate authorised person who instructed IMCA for the accommodation decision may or may not be the appropriate person from the relevant responsible body for the IMCA instruction for a care/accommodation review.

Instruction form

IMCA instruction forms need to be accessible to those who are responsible for making instructions whilst providing IMCA services with the essential information to ensure the instruction is legal and provide the information that they need to start the case.

Some instruction forms are very complicated and there is evidence that the NHS, in particular, are experiencing difficulties in completing some IMCA providers' forms due to their complexity and that this is a barrier to timely instruction or in some cases, instruction being made at all.

It is suggested that instruction forms are a maximum of one and a half pages long.

IMCA providers should review their instruction forms and consider what is essential and what information could be collected at a later date.

Essential information includes:

- Name of person
- Date of Birth
- Location of where person is now/contact details
- Decision
- Confirmation person lacks capacity for the specific decision
- Confirmation that there is nobody who is considered 'appropriate to consult'.
- Name, organisation and contact details of instructor and/or decision maker

Instruction Form Template

The instruction form template given below collects **the essential information** required for instruction to IMCA. Other desirable information has been added to enhance the information available to IMCA providers at an early stage.

The template can be used **and adapted** by IMCA providers to meet local need.

Template Instruction form for IMCA

Client details

Name:	DOB:
Current Location If hospital, which ward: Telephone number: Client contact name: Client contact telephone:	Home Address:
Gender: Female ☐ Male ☐	How does the person communicate?

African		Chinese		White British		Mixed background	
African/Caribbean		Indian		White Other		Black other	
Bangladeshi		Irish		Other(please specify)		Unknown	
Black British		Pakistani					

Nature of client's impairment

Mental Health Problems		Acquired brain injury		Learning Disability		Serious Physical Illness	
Unconsciousness		Dementia		Other (please state)		Not known	

Decision

Serious Medical Treatment ☐ Change in Residence ☐

Care Review ☐ Safeguarding ☐

What is the specific decision to be made?

Others Involved

Any family or friends? **No** ☐	**Yes** ☐ but not appropriate/willing/able to be consulted about the decision
If family/friends not appropriate to consult please say why:	

Client's capacity to make the decision

Please confirm that the client lacks capacity to make the specific decision at this time ☐

Has a capacity assessment been done? **For information on assessing capacity go to:** http://www.publicguardian.gov.uk/mca/assessing-capacity.htm	Yes ☐ No ☐	Name of person who assessed capacity: Date of assessment:

Contact Details

Details of person completing this form	**Who will make the best interests decision?**
Name	Name
Job	Job
Organisation	Organisation
Address	Address
Telephone	Telephone
Email	Email

Please detail any risk issues or incidents the IMCA service should be aware of:

I am instructing the IMCA service to do this work. I am authorised by the NHS organisation or local authority responsible for making this decision.	
Signed	Date
Name (please print)	Relationship to client

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