

Mental Capacity Act Policy

This policy describes the principles & procedures within the Mental Capacity Act and staff roles & responsibilities in applying this within clinical practice.

Key Words:	, best interests,	
Version:	5	
Adopted by:	Quality Assurance Committee	
Date Adopted:	19 March 2019	
Name of Author:	Greg Payne	
Name of responsible Committee:	Safeguarding Committee	
Date issued for publication:	March 2019	
Review date:	September 2020	
Expiry date:	1 March 2021	
Target audience:	All clinical staff	
Type of Policy	<u>Clinical</u>	Non Clinical
Which Relevant CQC Fundamental Standards?	Regulation 13: Safeguarding service users from abuse and improper treatment.	

Contents

Contents Page.....	2
VERSION CONTROL.....	3
Equality Statement.....	4
Due Regard.....	4
Definitions that apply to this policy.....	5
THE POLICY-	
1.0 Purpose of the Policy.....	6
2.0 Summary of the Policy.....	6
3.0 Introduction	7
4.0 Flowchart/Process Chart	9
5.0 Duties within the Organisation.....	10
6.0 Key Principles.....	10
7.0 Mental Capacity.....	11
8.0 Assessing Mental Capacity.....	12
9.0 The Decision Maker.....	14
10.0 Best Interests.....	14
11.0 Legal protection for action done in best interests.....	17
12.0 Restraint / Deprivation of Liberty.....	18
13.0 Payment for Goods and Services.....	19
14.0 Lasting Powers of Attorney (LPA).....	20
15.0 Court of Protection / Public Guardian.....	21
16.0 Court-appointed Deputies.....	22
17.0 Advance Decisions to Refuse Treatment.....	22
18.0 Excluded Decisions.....	25
19.0 Advance Statements.....	26

20.0 Research.....	27
21.0 Independent Mental Capacity Advocates (IMCAs).....	27
22.0 Criminal Offences.....	29
23.0 Training Needs.....	30
24.0 Monitoring Compliance and Effectiveness.....	31
25.0 Standards/Performance Indicators.....	32
26.0 References and Bibliography.....	34

REFERENCES AND ASSOCIATED DOCUMENTATION

Appendix 1 Policy Training Requirements.....	35
Appendix 2 NHS Constitution Checklist	36
Appendix 3 Stakeholder and Consultation.....	37
Appendix 4 Due Regard Screening Template Statement	38
Appendix 5 Privacy Impact Assessment Screening.....	40
Appendix 6 Form to record an assessment of capacity	41
Appendix 7 Best interests assessment form	42

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
Final version	November 2011	Harmonisation of the Mental Capacity Act guidelines following TCS.
Version 2	April 2014	Reviewed & updated.
Version 3	July 2016	Reviewed & updated.
Version 4	November 2017	Updated in line with MCA improvement plan.
Version 5	December 2018	Policy reviewed and re-written to meet with NICE guidelines NG108.

For further information contact:

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy.

Definitions that apply to this Policy

Mental capacity	The ability to make a decision.
Lasting Power of Attorney (LPA)	Sometimes one person will want to give another person authority to make a decision on their behalf. A power of attorney is a legal document that allows them to do so.
Advance Decision to Refuse Treatment (ADRT)	An advance decision to refuse treatment enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.
Court Appointed Deputy	A deputy appointed by the Court of Protection to make decisions for someone who is unable to do so on their own.
Independent Mental Capacity Act Advocate (IMCA)	The role of the IMCA is to support and represent the person who lacks capacity to make the specific decision.
Court of Protection	The Court of Protection deals with decision-making for adults who may lack capacity to make specific decisions for themselves. The Court is able to establish precedent and build up expertise in all issues related to lack of capacity.
Office of the Public Guardian	The Office of the Public Guardian is a government body that protects the private assets and supervises the financial affairs of people who lack mental capacity for making decisions.
Best Interests Checklist	A list of common factors that must always be considered when trying to work out someone's best interests.
Deprivation of Liberty Safeguards (DoLS).	The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care or treatment in order to keep them safe from harm.

1.0. Purpose of the Policy

- 1.1 Trust employees need to be able to determine a person's mental capacity in relation to the decisions they face throughout the care process. The purpose of this policy is to provide guidance to assist clinicians in understanding the factors that affect the ability to make decisions and to assess capacity and best interests where necessary.
- 1.2 The MCA imposes strict obligations upon staff when assessing capacity and when reaching decisions as to the best interests of incapacitated persons. It also provides legal protection to staff who fulfil these obligations and who follow the statutory procedures carefully and reasonably. The purpose of this policy is to support clinicians to apply these obligations to practice.

2.0. Summary and Key Points

Mental capacity is defined as the ability to make a particular decision at a specific time. The MCA (2005) establishes the following:

- A definition and a 2 stage test for capacity.
- Five guiding principles.
- A Code of Practice to provide guidance to anyone working with adults who may lack capacity to make specific decisions.
- Guidance relating to who should make decisions on behalf of people who lack capacity and the steps they should take to involve them.
- How and when to carry out a capacity assessment.
- A Best Interest Decision checklist to guide decision making on behalf of people without capacity.
- How people can plan ahead for if they lose capacity in the future i.e. A Lasting Power of Attorney (LPA), Advance Decisions to Refuse Treatment (ADRT) and Advance Statements
- Court Appointed Deputies, appointed by the Court of Protection, to make day to day decisions on behalf of someone who does not have capacity

The Act also provides new protections for people who lack capacity. These include:

- The Independent Mental Capacity Advocacy service
- The new criminal offences of ill treatment or willful neglect of a person who lacks capacity.

- The Court of Protection and the Office of the Public Guardian
- Court Appointed Deputies
- Guidelines on research involving people who lack capacity

3.0. Introduction

- 3.1 Leicestershire Partnership NHS Trust (the Trust) will implement and adhere to the Mental Capacity Act (2005) (MCA), its Code of Practice and associated regulations and any subsequent amendments.
- 3.2 The MCA provides a statutory framework for decision making in respect of people who lack or may lack the mental capacity to decide for themselves. It is designed to empower and protect vulnerable people who may not be able to make their own decisions and provides a framework for people with capacity to make plans for a time in the future when they may have lost mental capacity.
- 3.3 The MCA makes clear how capacity assessments are to be undertaken, who can take decisions in respect of an incapacitated person, in which situations they can do this and how they should go about it. It also enables people to plan ahead for a time when they may lose capacity. It replaced statutory schemes for Enduring Powers of Attorney (EPA) and Court of Protection receivers with reformed and updated schemes.
- 3.4 The interpretation and operation of the MCA changes following developments in case law and it is important that this Policy should be read in conjunction with any MCA Guidance Notes and associated documentation. This will be posted on the Trust Intranet and issued to the Managers as appropriate. The guidance notes and relevant documentation will be incorporated into the MCA Policy at review.
- 3.5 The MCA is accompanied by the Mental Capacity Act Code of Practice, which provides further guidance on how the MCA's provisions are to be applied in practice. Trust employees are required by law to have regard to the MCA and the Code of Practice whenever they deal with a patient in circumstances where the MCA applies.
- 3.6 The relationship between the MCA and the Mental Health Act 1983 (MHA) is complex. However, in general terms:
- Where a patient is detained under the MHA, they can be given treatment for their mental disorder and for symptoms of that mental disorder without their consent. In these circumstances, the MCA will not apply and the provisions of Part IV of the MHA should instead be relied upon when determining whether to provide treatment;

- Where a detained patient requires treatment which is not for their mental disorder or any symptom of it (for example, treatment for a medical condition which is not related to their mental disorder), they cannot be provided with this treatment without their consent. In these circumstances Part IV of the MHA cannot be relied upon in order to give treatment without the patient's consent, and instead the provisions of the MCA will apply. Either the patient's valid consent to treatment must be obtained, or a best interests decision must be properly reached where the patient is assessed as lacking capacity to give their consent;
- Where a patient is not detained under the MHA, their valid consent to treatment is required and they cannot be treated without consent under Part IV. The provisions of the MCA will apply in full in these cases.

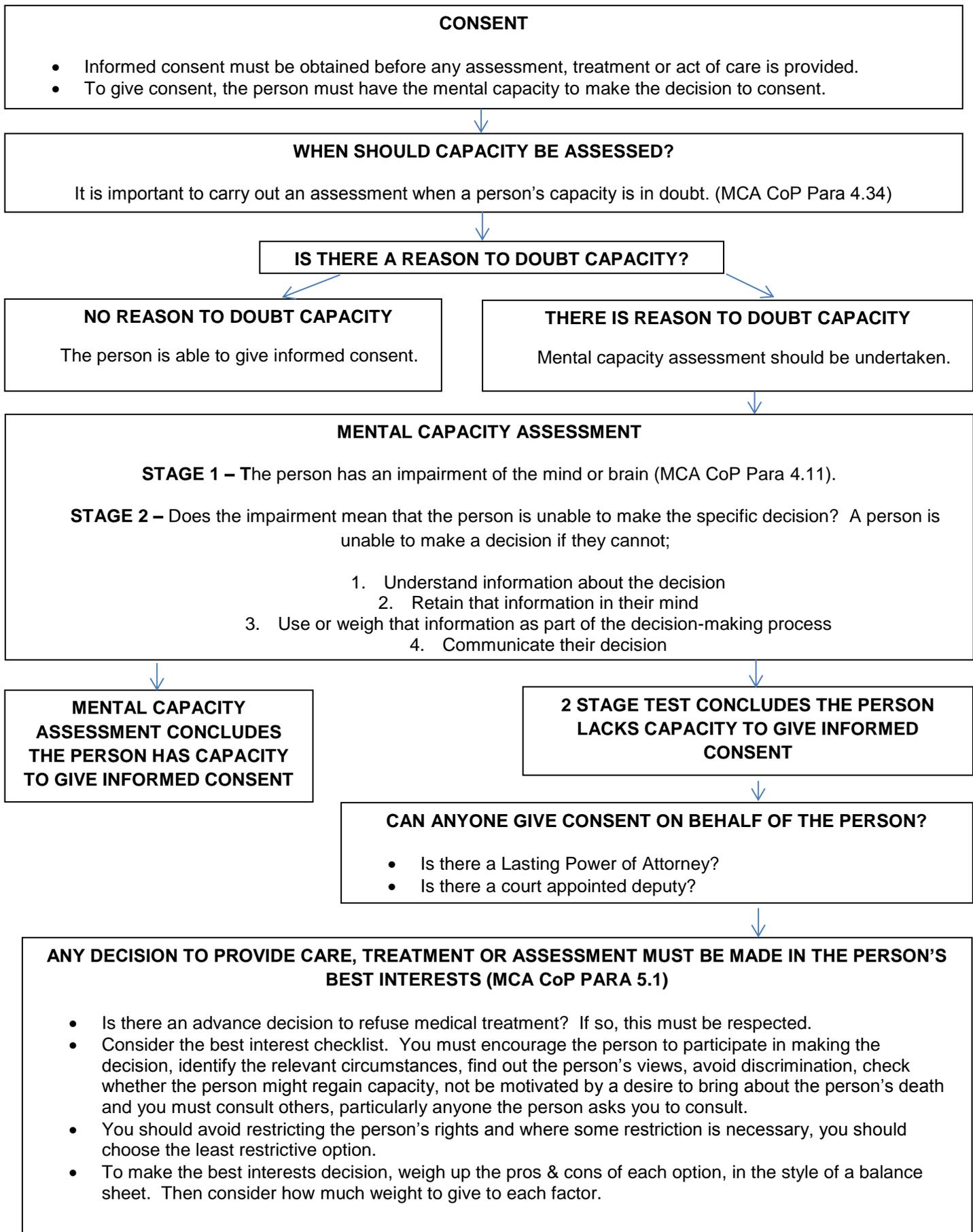
3.7 The MCA only applies to patients aged 16 or over. Where the patient is a child:

- If the child is detained under the MHA, they can be given treatment for their mental disorder and for symptoms of that mental disorder without consent under Part IV of the MHA;
- If the child is detained under the MHA and treatment is required for a medical condition which is not related to their mental disorder, consent should be sought from a person with parental responsibility for the child, or from the child themselves if they are competent to give consent.
- If the child is not detained under the MHA, consent to treatment should be sought either from a person with parental responsibility for the child, or from the child themselves if they are competent to give consent. Staff should again refer to the Trust's policy on consent in this situation.

3.8 Chapter 13 of the MCA Code of Practice gives further guidance on the relationship between the MCA and the MHA.

3.9 Any issues regarding the implementation and practice of the MCA should be brought to the attention of the LPT Safeguarding Team as and when they arise.

4.0. Flowchart/process chart



5.0. Duties within the Organisation

- 5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.
- 5.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.
- 5.3 The Executive Safeguarding Lead within LPT is the Deputy Chief Nurse. The executive lead is responsible for ensuring a policy is in place.
- 5.4 Responsibility of all clinical staff;

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given verbally and / or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision. Appropriate records should be maintained.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

6.0 Key Principles

- 6.1 The MCA details five guiding principles which health and social care staff must have regard to at all times when dealing with a person who lacks or may lack capacity in relation to a matter:

6.1.1 The presumption of capacity

Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise

6.1.2 Individuals being supported to make their own decisions

A person must be given all practicable help to reach their own decision before anyone treats them as not being able to make that decision

6.1.3 Unwise decisions

Just because a person makes what might seem an unwise decision, they should not be treated as lacking in capacity to make that decision

6.1.4 **Best interests**

An act done or decision made under the MCA for or on behalf of a person who lacks capacity must be done or made in their best interests

6.1.5 **Least restrictive option**

Anything done for or on behalf of a person who lacks capacity should interfere with that person's basic rights and freedoms as little as possible

7.0 Mental Capacity

7.1 The MCA defines incapacity as follows; 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 an impairment of, or a disturbance in the functioning of, the mind or brain.

7.2 The MCA sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a 'decision-specific' test: that is to say, a person's capacity is only ever assessed in relation to a specific decision that needs to be taken, and not in general. It is also a time specific test: that is to say, their capacity is assessed to take that decision at that time, and again not in general.

7.3 Anyone assessing someone's capacity to make a decision for themselves must use the following two-stage test of capacity:

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind works? (It does not matter whether the impairment or disturbance is permanent or temporary).
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

The answer to the second question will be determined by applying the four stage functional test set out below at paragraph 8.5.

7.4 No one can simply be labelled 'incapable' as a result of a particular medical condition or diagnosis. Instead a person must always be assessed properly applying the MCA capacity test set out in this document, and an objective view must be taken as to whether they have the capacity or not to take the decision in question.

7.5 A lack of capacity cannot be established merely by reference to:

- A person's age or appearance, or
- A condition, or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity

7.6 Any question as to whether a person lacks capacity must be decided on the balance of probabilities.

8.0 Assessing Mental Capacity

8.1 Before the mental capacity assessment can be undertaken, the following criteria must be met;

- Age; the person being assessed is at least 16 years old.
- Decision; the decision must be within the remit of the Mental Capacity Act.
- Impairment or disturbance; the assessor must have a reasonable belief that the person concerned has an impairment of, or disturbance in the functioning of, the mind or brain.

8.2 There is a positive legal obligation on those assessing a person's mental capacity to help and support them during the assessment process. The aim of this is to assist the person to pass the assessment so they can make their own decision. A record should be made of the help and support provided.

Practicable steps to help the person could include;

- Communicating information in a way appropriate to the person concerned.
- Using others who could help the person understand the information.
- Adjusting the environment.

8.3 The second part of the capacity test involves assessing whether a person who is suffering from some sort of mental impairment or disturbance is consequently unable to make the decision in question at the time it needs to be made. A person's ability to make a decision is assessed by applying the four stage functional test set out below.

8.4 Before a person is asked to reach a particular decision, they must be given all of the relevant information they need to make a fully informed decision. When assessing capacity it is inappropriate to start with a blank canvas. The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be considered (CC v KK and STCC 2012, EWCOP 2136).

8.5 The person will be unable to make a decision for themselves if they are unable to do any one of the following four things:

- Understand the information relevant to the decision, or
- Retain that information, or
- Use or weigh that information as part of the process of making the decision, or
- Communicate their decision (whether by talking, using sign language or any other means).

8.6 A person is not to be regarded as unable to understand the information relevant to a decision if they are able to understand an explanation of it given to them in a way that is appropriate to their circumstances (for example, by using simple language, visual aids or any other means).

8.7 The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision. Capacity may be established where a person is able to understand and retain information long enough to make an informed decision.

8.8 The information relevant to a decision includes information about the reasonably foreseeable consequences of:

- Deciding one way or another, and
- Failing to make the decision.

8.9 There are several further factors which must be taken into account when assessing capacity:

- **Fluctuating / temporary capacity**

A person's mental capacity can fluctuate or be temporarily impaired due to mood or depression or an underlying physical disorder e.g. urinary tract infection. When assessing capacity, a view should also be taken as to whether the person might regain capacity in the future, and if so, when this is likely to be. If the decision can be postponed until the person regains capacity, it should be postponed, to allow the person to reach their own decision at that later time.

- **Specific decision**

A person may have the capacity to make some decisions but not others. A person's capacity should be assessed in the context of the specific decision that needs to be made. For example, a person might have the necessary mental capacity to decide what to wear or what to eat, but might lack the capacity to take more serious decisions regarding where to live or what medical care they should receive.

- **Information.**

Any information relevant to the decision should be provided in a format that the person is best able to understand.

- **Pressure**

Carers or other family members may sometimes exert pressure on

Trust staff to treat a patient as lacking capacity to take certain decisions and to care for them as the family would wish. Trust staff must not be influenced by such pressure, but must instead reach their own view as to the patient's capacity by applying the principles set out in the MCA, the Code of Practice and this document. However, the carers' and family members' views will be relevant when considering what might be in the best interests of an incapacitated patient.

8.10 Staff should routinely try to ascertain the existence (or not) of any Lasting Power of Attorney, advance decision or advance statement at initial assessments and reviews. Changes should be documented in the person's records.

8.11 The Code of Practice provides guidance on this issue in Chapter 4.

9.0 The Decision Maker

9.1 Where a person is assessed as lacking the capacity to make a particular decision, the MCA stipulates that whatever act is done or decision is made on behalf of that person must be done or made in the person's best interests. The person who decides what would be in the person's best interests is referred to in the Code of Practice as the "decision-maker".

9.2 The decision-maker in any given case will be the person who is proposing taking action in connection with the care or treatment of an adult who lacks capacity, or who is contemplating making a decision on their behalf. The identity of the decision maker will depend upon the nature of the proposed action and the context in which it is proposed:

- Where the decision relates to medical treatment, the doctor proposing the treatment will be the decision maker;
- If the person has a care manager or care co-ordinator, they will generally be the decision maker on general issues of welfare and finance;
- Where nursing care is provided and a decision about nursing care needs to be reached, the nurse will be the decision-maker;
- For most other day-to-day actions or decisions, the decision-maker will be the person directly involved with the person at the time.

9.3 The Code of Practice provides guidance on this issue in Chapter 5.

10.0 Best Interests

10.1 The MCA provides a checklist of factors that a decision-maker must work through in deciding what is in an incapacitated person's best interests. This is referred to as the 'Best Interests Checklist'. All of the factors in the Best

Interests Checklist must be taken into account by the decision-maker when reaching a decision as to best interests. In addition, the decision-maker must take into account any other factors that are relevant in the circumstances.

- 102 In determining for the purposes of the MCA what is in a person's best interests, the decision-maker must not make their determination merely on the basis of:
- The person's age or appearance, or
 - Any condition affecting them, or any aspect of their behaviour, which might lead others to make unjustified assumptions about what might be in their best interests.
- 103 The decision-maker must consider all the relevant circumstances and, in particular, must take the steps set out below.
- 104 The decision-maker must consider whether it is likely that the person will at some time have capacity in relation to the matter in question. If it appears likely that the person will do so, the decision-maker must go on to consider when that is likely to be.
- 105 The decision-maker must, so far as is reasonably practicable, permit and encourage the person to participate, or to improve his/her ability to participate, as fully as possible in the decision itself and in any action subsequently taken.
- 106 The decision-maker must consider so far as may be reasonably ascertainable:
- The person's past and present wishes and feelings, and in particular any relevant written statement made by them when they had capacity. This will include any advance statement that the person may have made.
 - Any beliefs and values of the person that would be likely to influence their decision if they had capacity, and
 - Any other factors that they would be likely to consider if they were able to do so.
- 107 The decision-maker must take into account, if it is practicable and appropriate to consult them, the views of the following people as to what would be in the person's best interests:
- Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind
 - Anyone engaged in caring for the person or interested in his/her welfare (this will include family members and carers)
 - Any donee of a lasting power of attorney granted by the person,

and/or

- Any deputy appointed for the person by the court.

- 108 When assessing best interests, a 'balance sheet approach' should be taken. Using this approach ensures both positive and negative factors related to a decision are taken into account. Decision-makers should ensure that the record of their best interests' assessment shows this balanced approach. The assessment process should inform the decision as opposed to recording the assessment to fit a decision that has already been taken.
- 109 A best interest's decision needs to be taken in every case where a course of action is proposed for a person who lacks the capacity to consent to that course of action. This includes all aspects of the care and treatment of such a person.
- 10.10 However, not all best interests' decisions need to be formally recorded. In general terms, best interest's decisions concerning matters of day to day personal care and normal activities of daily living for an incapacitated person will not normally need to be formally recorded. Examples might include choosing what clothes the person should wear on a cold day, or deciding what the person should eat for lunch. Such decisions form part of routine care planning practices.
- 10.11 Clinicians should consider recording more significant best interests decisions using the appropriate form which can be located in the Electronic Patient Record.
- 10.12 The following are some examples of best interest's decisions where consideration should be given for using the best interests form:
- All decisions as to the care and treatment (beyond matters of day to day personal care and normal activities of daily living) of a mentally incapacitated patient whose care is authorised under Deprivation of Liberty Safeguard (DoLS).
 - Medical treatment for a detained patient where the proposed treatment is not for their mental disorder or any symptom of their mental disorder. The medical treatment therefore being provided under MCA.
 - Care planning and mental health treatment decisions for patients whose care is authorised under DoLS.
 - Decisions as to ongoing care which will be subject to future review.
 - Decisions which may involve restricting the liberty of patients deprived of their liberty, such as those around high level observations.
 - Issues of dispute with family members or other interested parties.
 - A change of accommodation for patient's whose care has been authorised under DoLS or on discharge from detention.
- 10.13 A record should be made each time a new best interests decision is required.

This will include each time there is a change in the proposed treatment regime or care plan for a mentally incapacitated patient deprived of their liberty. Unless there are major changes in capacity or proposed interventions only one form should be completed per admission with minor changes being recorded in routine clinical notes.

- 10.14 Any record should include the process used to reach the decision, not just the decision reached.
- 10.15 A person's best interests may change over time and so any best interests' decision should be subject to review. The Act does not state how regularly reviews should take place.
- 10.16 Sometimes there might be disagreement or dispute as to what would be in the best interests of an incapacitated person, for example between clinicians and family members. In the event of a dispute, staff should seek local resolution if at all possible. The following may assist the decision maker to resolve the dispute:
- Involve an advocate who is independent of all parties involved (see section 21)
 - Get a second opinion as to capacity and/or best interests
 - Hold a strategy meeting of all involved
 - Consider mediation
- 10.17 Where local resolution of a dispute is not possible despite all efforts of the decision-maker, consider with line management whether a legal perspective should be obtained. Physical attendance of a lawyer at strategy meetings should be a last resort and only after agreement of senior managers. The Court of Protection has jurisdiction to resolve disputes as to the capacity and/or best interests of an incapacitated person, and an application to the Court might be necessary in some cases. Advice can be sought from the Trust Mental Health Legislation Development Lead.

The Code of Practice provides guidance on this issue in Chapter 5.

11.0 Legal protection for action done in best interests

- 11.1 The MCA gives legal protection to health and social care staff who take action in connection with the care or treatment of a person who lacks capacity. A staff member will have legal protection under the MCA where they:
- have taken reasonable steps (applying the principles of the MCA and the Code of Practice) to establish whether the person has capacity in relation to the matter in question, and
 - when carrying out the action, the staff member reasonably believes the person lacks capacity in relation to the matter, and that it will be their best interests for the act to be done.

112 However there are certain limitations on the legal protection that the MCA provides. In particular:

- **Restraint.** Actions which involve restraint of a person who lacks capacity will only be justifiable under the MCA where certain further conditions are satisfied. These are dealt with in section 12 below;
- **Deprivation of liberty.** The MCA does not allow staff to deprive a person who lacks capacity of their liberty. This is also dealt with in section 12 below;
- **LPAs.** Where an attorney has been appointed under a Lasting Power of Attorney to take health and welfare decisions, staff must not act contrary to a decision made by that attorney, as long as the attorney is acting within the scope of his/her authority. Lasting Powers of Attorney are dealt with in section 11 below;
- **Deputies.** Where the court has appointed a deputy to take health and welfare decisions, staff must not act contrary to a decision made by that deputy, as long as the deputy is acting within the scope of his/her authority. Court- appointed deputies are dealt with in section 13 below;
- **Advance decisions.** Where a person has made a valid and applicable advance decision, staff must not act contrary to that advance decision, even if they believe it would be in the incapacitated person's best interests to do so. Advance decisions are dealt with in section 14 below.

113 The Code of Practice provides guidance on this issue in Chapter 6.

12.0 Restraint/Deprivation of Liberty

121 Section 6 of the MCA defines restraint as:

- the use or threat of force to make an incapacitated person do something that they are resisting, or
- any restriction of an incapacitated person's freedom of movement, whether or not the person resists.

122 Restraint of an incapacitated person is only permitted under the MCA if:

- the person using it reasonably believes that the restraint is **necessary to prevent harm** to the incapacitated person, and;
- the amount or type of restraint used, and the duration of that restraint, is proportionate to the likelihood and seriousness of the harm.

123 Restraint of an incapacitated person will only be justifiable if these two

conditions are satisfied, regardless of whether staff believe that restraint would be in the best interests of an incapacitated person

- 124 The MCA does not provide any protection for an act which deprives an incapacitated person of his or her liberty. "Deprivation of liberty" is undefined in the MCA, but in general terms an incapacitated person will be deprived of their liberty where action is taken that amounts to more than mere restraint under the definition above.
- 125 Provisions concerning the deprivation of liberty of persons who lack capacity were introduced in April 2009. Staff should refer to the Trust's Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards.
- 126 Further advice and guidance should be sought from the Trust Safeguarding Team.
- 127 The MCA Code of Practice provides guidance on this in Chapter 6.

13.0 Payment for Goods and Services

- 13.1 If a person lacks capacity to arrange for payment for necessary goods and services, the MCA allows a carer to arrange payment on their behalf.
- 13.2 'Necessary' means something that is suitable to the person's condition in life (their place in society, rather than any mental or physical condition) and their actual requirements when the goods or services are provided. The aim is to make sure that people can enjoy a similar standard of living and way of life to those they had before lacking capacity.
- 13.3 The carer must first take reasonable steps to check whether a person can arrange for payment themselves, or has the capacity to consent to the carer doing it for them. If the person lacks the capacity to consent or pay themselves, the carer must decide what goods or services would be necessary for the person and in their best interests.
- 13.4 The carer can then lawfully deal with payment for those goods and services in one of three ways:
- If neither the carer nor the person who lacks capacity can produce the necessary funds, the carer may promise that the person who lacks capacity will pay. However the carer may not be comfortable with this, and equally the supplier may not be willing to accept this arrangement;
 - If the person who lacks capacity has cash, the carer may use that money to pay for goods or services (for example, to pay the

milkman or the hairdresser).

- The carer may choose to pay for the goods or services with their own money. If so, the person who lacks capacity must pay them back. This may involve using cash in the person's possession or running up an IOU. Someone with legal authority to handle the person's financial affairs may need to be approached to obtain reimbursement

13.5 Carers must keep bills, receipts and other proof of payment when paying for goods and services. They will need these documents when asking to get money back.

13.6 The Act does not give a carer or care worker access to a person's income or assets. Nor does it allow them to sell the person's property. Anyone wanting access to money in a person's bank or building society will need formal legal authority (e.g. a Lasting Power of Attorney or Court Order).

13.7 Sometimes another person will already have legal control of the finances and property of a person who lacks capacity to manage their own affairs. This could be an attorney acting under a registered Enduring Power of Attorney or an appropriate Lasting Power of Attorney, or a deputy appointed by the Court of Protection. Alternatively it could be someone that has the right to act as an 'appointee' (under Social Security Regulations) and claim benefits for a person who lacks capacity to make their own claim and use the money on the person's behalf. The MCA makes clear that a carer cannot make arrangements for goods or services to be supplied to a person who lacks capacity if this conflicts with a decision made by someone who has formal powers over the person's money and property, such as an attorney or deputy acting within the scope of their authority.

13.8 The MCA Code of Practice provides guidance on this issue in Chapter 6.

14.0 Lasting Powers of Attorney (LPA)

14.1 The MCA allows a person who is aged 18 or over and who has mental capacity to appoint an attorney to take certain decisions on their behalf if they should lose capacity in the future. The MCA introduces two forms of LPA:

- Property and affairs LPAs replaced Enduring Powers of Attorney in the area of property and financial affairs;
- Personal welfare LPAs are new under the MCA and allow a person aged 18 or over to confer upon another person the authority to make decisions concerning personal welfare matters (including medical treatment and social care) if the person granting the authority should lose capacity in the future.

14.2 Where a person is acting as an attorney under a personal welfare LPA, they

will be entitled to take decisions regarding the health and social care of the incapacitated person that appointed them; as long as they act within the scope of the authority they have been given. Health and social care staff will be required to go along with the decisions the attorney takes.

- 14.3 However, a personal welfare attorney will only be able to take decisions regarding life sustaining treatment where they have been granted the specific authority to do so by the incapacitated person in the LPA document.
- 14.4 An attorney cannot refuse their consent to treatment given to a detained patient under Part IV of the MHA.
- 14.5 All attorneys are under a duty to have regard to the Code of Practice and to act in accordance with the incapacitated person's best interests.
- 14.6 All LPAs must be registered with the Office of the Public Guardian when they are created. An LPA has no effect unless it has been registered in this way. When dealing with a person who claims to be the valid attorney of an incapacitated person under an LPA, Trust staff should ask to see a copy of the LPA which has been stamped on every page by the Office of the Public Guardian to confirm that it has been registered. Staff should also check the stamped LPA to confirm the nature and extent of the attorney's authority to take decisions.
- 14.7 The Code of Practice provides guidance on this issue in Chapter 7.

15.0 Court of Protection / Public Guardian

- 15.1 The MCA provides two public bodies to support the statutory framework, both of which are designed around the needs of those who lack capacity:

15.1.1 The Court of Protection

Prior to the MCA coming into force, the Court of Protection had limited jurisdiction over the property and financial affairs of incapacitated people. The MCA expanded the role of the Court of Protection, and the new Court now has jurisdiction over all matters relating to decision-making affecting adults who lack capacity, including health and social care decisions. The Court of Protection is now the final arbiter in matters of mental capacity and best interests. It has its own procedures and nominated judges.

15.1.2 Public Guardian

The Office of the Public Guardian and its staff are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court

make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

15.2 Further guidance is provided at Appendix 4. The MCA Code of Practice provides guidance on these issues in Chapter 8.

16.0 Court-appointed Deputies

16.1 The MCA provides for a system of court-appointed deputies to replace the current system of receivership in the Court of Protection. Deputies are able to take decisions on welfare, healthcare and/or property or financial matters as authorised by the Court. A deputy will only be appointed if the Court cannot make a one-off decision to resolve the issues.

16.2 A deputy may be appointed by the court to take decisions concerning the personal welfare of an incapacitated person. This might include decisions regarding the health or social care the incapacitated person is to receive. Health and social care staff will be required to go along with the decisions a deputy takes, as long as the deputy acts within the scope of the authority he / she has been given by the Court.

16.3 However a deputy does not have the power in any circumstances to refuse consent to life-sustaining treatment for an incapacitated person.

16.4 A deputy also cannot refuse consent to treatment given to a detained patient under Part IV of the MHA.

16.5 Deputies are under a duty to have regard to the Code of Practice and to act in accordance with the incapacitated person's best interests.

16.6 When dealing with a person who claims to be the court-appointed deputy of an incapacitated person, Trust staff should ask to see a copy of the sealed court order which gives the deputy their authority. Staff should also check the order to confirm the nature and extent of the attorney's authority to take decisions. All deputies are provided by the Court of Protection with extra copies of the order to demonstrate their authority when required.

16.7 The Code of Practice provides guidance on this issue in Chapter 8.

17.0 Advance Decisions to Refuse Treatment

17.1 Before the MCA came into force, a person with capacity could make an "advance directive" to refuse certain specified medical treatment if he/she should lose mental capacity in the future.

- 17.2 The MCA updates and reforms the law with regard to such statements. Under the MCA these are known as “advance decisions”. The MCA sets out clear statutory rules and safeguards confirming the procedure by which a person may make a decision in advance to refuse treatment if they should lose capacity in the future.
- 17.3 An advance decision can only be made by a person who is aged 18 or over at a time when that person has the necessary mental capacity to make it.
- 17.4 The advance decision must specify the treatment that is being refused and the circumstances in which it is being refused.
- 17.5 An advance decision does not need to be in writing unless it applies to life-sustaining treatment. There are specific rules about the way in which an advance decision to refuse life sustaining treatment must be made and these are set out below. An advance decision which does not relate to life sustaining treatment may be made orally or in writing and there is no specific statutory form that must be used to make an advance decision of any kind.
- 17.6 If the advance decision concerns life-sustaining treatment it must follow a particular format set out in the MCA. An advance decision to refuse life sustaining treatment must be:
- Made in writing
 - Signed by the person making it
 - Witnessed by a third party as having been validly signed by the person making it
 - Accompanied by a separate statement that the advance decision is to apply even if life is at risk
 - That separate statement must also be signed by the person making the advance decision, and their signature must again be witnessed by a third party
- 17.7 In general, an advance decision may be withdrawn or altered by the person who made it at any time by any means. However, in the case of an advance decision to refuse life-sustaining treatment, any withdrawal or alteration must be made in writing.
- 17.8 In order to be legally binding, an advance decision must be both:
- Valid, and
 - Applicable

17.8.1 Health and social care staff must abide by an advance decision that is both valid and applicable, unless treatment is to be given under Part IV of the MHA. This is dealt with in more detail below.

17.9 An advance decision will be valid where it has been made in the correct form and where there is no reason to doubt that it reflects the genuine wishes of the incapacitated person at the time they had capacity in relation to the matter. There may be reason to doubt the validity of an advance decision where:

- There is evidence that it was revoked by the incapacitated person whilst they still had capacity, or
- There is evidence that the incapacitated person changed their mind about the matter whilst they still had capacity, or
- There is evidence that the incapacitated person made the advance decision under duress or coercion, or
- Since making the advance decision the incapacitated person appointed an attorney under an LPA with authority to take decisions in relation to the same matter

17.10 An advance decision will be applicable where:

- It sets out clearly the treatment that is being refused and the circumstances in which it is to be refused, and
- The treatment proposed is the same treatment set out in the advance decision, and the circumstances are the same as in the advance decision

17.11 Where a detained patient requires treatment for their mental disorder or a symptom of that disorder, they can be given that treatment without their consent under Part IV MHA. In these circumstances, staff can give treatment even if the patient has made an advance decision to refuse that treatment and that advance decision would otherwise be valid and applicable.

17.12 Wherever possible an oral advance decision should be recorded in a person's care record. If there is any doubt or dispute about the existence, validity or applicability of an advance decision then it should be referred to the Court of Protection for determination.

17.13 There are agreed documents which can be used for advance decisions and advance statements which are detailed in the Trust Advance Decisions Policy.

17.14 The MCA Code of Practice provides guidance on this issue in Chapter 9.

18.0 Excluded Decisions

18.1 The MCA covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. However there are certain decisions which can never be made on behalf of a person who lacks capacity to make those specific decisions. This is because they are either so personal to the individual concerned, or governed by other legislation.

18.2 The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity. No best interest's decision can be taken in respect of these matters. There will be no question of an attorney consenting to these decisions, or of the Court of Protection making an order or appointing a deputy to provide the requisite consent.

18.3 These decisions may be summarised as follows:

18.3.1 Decisions concerning family relationships

- Consent to marriage or a civil partnership
- Consent to have sexual relations
- Consent to a decree of divorce on the basis of two years' separation
- Consent to the dissolution of a civil partnership
- Consent to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property.
- Consent under the Human Fertilisation and Embryology Act (1990).

18.3.2 Voting rights

Nothing in the Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person who lacks capacity to vote.

18.3.3 Unlawful killing or assisted suicide

Nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

18.4 Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves (for example, consenting to have sexual relations), this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

18.5 The MCA also does not apply where treatment is to be given to a detained patient under Part IV MHA.

19.0 Advance Statements

19.1 An advance statement is a document which is completed by a patient, at a time when they have the necessary mental capacity, to make known their wishes regarding care, treatment and other personal matters should they become unwell.

19.2 Unlike an advance decision, an advance statement will not set out to specify which types of care or treatment the person does not want to receive if they should lose capacity in the future. If a person wishes to stipulate which types of treatment they should not be given when they lack capacity, they should be advised to make a valid and applicable advance decision, bearing in mind the relevant provisions of the MCA and the formal requirements discussed in paragraph 14 above.

19.3 The purpose of an advance statement is:

- To set out the person's wishes and preferences in terms of medical treatment and relapse management;
- To identify those trusted relatives, carers and/or advocates who may be contacted in an emergency or consulted with by health professionals;
- To indicate what practical arrangements the individual may wish to have addressed if admitted to hospital, e.g. regarding care of dependents, safeguarding their home and managing their possessions.

19.4 Unlike an advance decision, an advance statement will not be legally binding upon health or social care professionals. However, the MCA states that when reaching a best interests decision concerning a person who lacks capacity, a decision maker must have regard to any relevant written statements made by that person at a time when they had capacity. Decision makers will therefore be under a duty to consider the content of an advance statement when reaching a best interests decision.

19.5 An advance statement is a document that a person can write themselves, with help from their care co-ordinator or any other person. It can be written as part of a care co-ordination review, or at any other time.

20.0 Research

- 20.1 The MCA sets out a new legislative framework to cover situations where “intrusive” research is to be carried out on or in relation to a person who lacks capacity. “Intrusive” research is any research which would ordinarily require a person’s consent to be undertaken lawfully. However it does not include clinical trials, which continue to be covered by the Medicines for Human Use (Clinical Trials) Regulations 2004.
- 20.2 Research covered by the MCA cannot include people who lack capacity to consent to the research unless it has the approval of the “appropriate body”. This will be the relevant Research Ethic Committee (“REC”). Approval will only be granted where certain conditions set out in the MCA are satisfied.
- 20.3 Research covered by the MCA must also follow the requirements of the MCA to:
- Consult with and consider the view of carers and others as to an incapacitated person’s involvement in the research project;
 - Treat that person’s interests as paramount;
 - Respect any objections of the person during the research.
- 20.4 The Code of Practice provides guidance on this issue in Chapter 11.

21.0 Independent Mental Capacity Advocates (IMCAs)

- 21.1 The IMCA provides additional representation and support to incapacitated persons in certain clearly defined circumstances.
- 21.2 The MCA places a duty upon decision-makers to consult with those close to an incapacitated person when deciding what course of action might be in that person’s best interests. However, some incapacitated people may not have anyone close to them (e.g. no close family or friends) with whom a decision-maker might consult when deciding upon best interests. The role of an IMCA is to provide support and representation to an incapacitated person who has no one else close to them to provide such support, in certain circumstances where a best interest decision needs to be taken. The decision-maker will be under a duty to involve and consult with the IMCA when deciding upon best interests.
- 21.3 Health and social care staff are under a duty to instruct an IMCA to represent and support an incapacitated person in the following circumstances:

21.3.1 Serious medical treatment

- Where an NHS body is proposing to provide, or secure the provision of, “serious medical treatment” for an incapacitated

person, and where that NHS body is satisfied that there is no one other than a paid carer with whom it would be appropriate to consult in determining what would be in the person's best interests, an IMCA must be instructed to represent the patient

- “Serious medical treatment” is defined as treatment which involves providing, withdrawing or withholding treatment in circumstances where:
 - There is a fine balance between the benefits and risks to the patient or;
 - Where there is a choice of treatments, the decision as to which one is finely balanced, or;
 - What is proposed would be likely to involve serious consequences for the patient.
- However there will be no duty to instruct an IMCA where serious medical treatment is provided under Part IV of the Mental Health Act 1983.

21.3.2 Long term accommodation by the NHS

- Where a NHS body proposes to accommodate an incapacitated person in a hospital where the patient meets the acid test and is deprived of their liberty legal authority must be obtained for the deprivation. This can be through the MHA, DoLS or an order from the Court of Protection. The most appropriate legislation must be used which best meets the patient's individual circumstances. If appropriate an IMCA will be instructed in line with legal process. Staff should refer to the Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards.

However there will be no duty to instruct an IMCA where accommodation is provided under Part IV of the Mental Health Act 1983.

Long term accommodation by a local authority

- Where a local authority proposes to accommodate an incapacitated person in a care home (or move them to another care home) where the patient meets the acid test and is deprived of their liberty legal authority must be obtained for the deprivation. This can be through the DoLS or an order from the Court of Protection. If appropriate an IMCA will be instructed in line with legal process. Staff should refer to the Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards. However there will be no duty to instruct an IMCA where accommodation is provided under

Part IV of the Mental Health Act 1983.

21.4 An IMCA may also be instructed in:

- a care review regarding an incapacitated person, or
- an adult safeguarding case that involves a vulnerable incapacitated person where the decision-maker is satisfied that having an IMCA will be of a particular benefit to the person who lacks capacity.

21.5 An IMCA must decide how best to represent and support the person who lacks capacity that they are helping. They:

- must confirm that the person instructing them has the authority to do so
- should interview or meet in private the person who lacks capacity, if possible
- must act in accordance with the principles of the MCA and the Code of Practice
- may examine any relevant records that the MCA allows them access to
- should get the views of professionals and paid workers providing care or treatment for the person who lacks capacity
- should get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity
- should get hold of any other information they think will be necessary
- must find out what support a person who lacks capacity has had to help them make the specific decision
- must try to find out what the person's wishes and feelings, beliefs and values would be likely to be if the person had capacity
- should find out what alternative options there are
- should consider whether getting another medical opinion would help the person who lacks capacity, and
- must write a report on their findings for the local authority or NHS body that instructed them

21.6 The IMCA can challenge the decision-maker on behalf of the person lacking

capacity if he/she does not agree with the decision that is ultimately reached.

21.7 Further Guidance regarding the role of the IMCA is provided at Appendix 5. The Code of Practice provides guidance on this issue in Chapter 10.

22.0 Criminal Offences

22.1 The MCA introduces 2 new criminal offences. These are:

- ill treatment of a person who lacks capacity; and
- wilful neglect of a person who lacks capacity

22.2 These offences may be committed by:

- anyone responsible for an incapacitated person's care: this could include family carers, health and social care staff in hospitals or care homes and those providing care in the person's home;
- any donee of a Lasting Power of Attorney or an Enduring Power of Attorney;
- any deputy appointed by the Court

22.3 A person found guilty of such an offence may be liable to a fine, imprisonment for a term of up to five years, or both.

23.0 Training needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as mandatory. All Trust staff in a clinical role must attend a face to face training session when current compliance is due to expire. Refresher training must be completed via e-learning every 3 years.

The governance group responsible for monitoring the training is the Trust Safeguarding Committee.

24.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
9	Consent should be sought and obtained before any care, intervention or treatment.	Paragraph 5.4, page 9.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
10	Capacity assessments must be clearly recorded in the records.	Paragraph 7.4, page 10.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
10	Records should evidence the practical steps taken to support the person to make the decision for them self.	Paragraph 7.4, page 10.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
13	Records evidence that reference is made to the best interests checklist by the decision maker when reaching a decision as to best interests.	Paragraph 10.1, page 13.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
13	Records evidence that the decision maker has considered the person's past and present wishes and feelings.	Paragraph 10.6, page 13.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
14	Records evidence that the decision maker has consulted with anyone named by the person, anyone caring for the person and anyone appointed to act on the person's behalf.	Paragraph 10.7, page 14.	Clinical audit.	Mental Capacity Act Clinical Forum, reporting to the Safeguarding Committee.	Annual.
26	Relevant employees have attended	Paragraph 23, page 26.	Workforce training reports.	Mental Capacity Act Clinical Forum,	Monthly.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	mandatory Mental Capacity Act training as identified in this policy.			reporting to the Safeguarding Committee.	

25.0. Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CCG SAT / NICE NG108; Safeguarding training programme will include the Mental Capacity Act, including relevant case law.	Mental Capacity Act training lesson plan.
CCG SAT / NICE NG108; the Trust audit programme includes mental capacity audits which provide clear evidence of actions taken resulting from the findings of the audit.	Mental capacity audits are managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CCG SAT / NICE NG108; the Trust Mental Capacity Act policy includes the practical application of the Act including capacity assessments and best interest decision making.	Mental Capacity Act policy includes required content and is in date.
CCG SAT; the Trust Consent to Examination and Treatment Policy includes the application of the MCA when seeking consent.	Consent to Treatment policy includes required content and is in date.
CQC E6.1; do staff understand the relevant consent and decision making requirements of legislation and guidance, including the MCA.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CCG SAT; clear expectations regarding the MCA are specified in all job descriptions and through the appraisal process.	Job descriptions templates make reference to legislative requirement.
CCG SAT; all staff are aware how to access support and guidance relating to the MCA.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CCG SAT; safeguarding supervision includes the application of the MCA in practice.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CCG SAT; the Trust has systems in place to capture, triangulate and action findings from incidents relating to the MCA.	Quarterly report to the MCA Clinical Forum from Ulysses detailing MCA related incidents, actions and learning.
CCG SAT; all staff have access to the MCA Code of Practice.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.

CCG SAT; the MCA policy will include how to raise concerns should an employee feel that decisions are not being made in the best interest of the patient.	Mental Capacity Act policy includes required content and is in date.
CCG SAT; the MCA policy will detail how patients who lack capacity are supported as much as possible to continue to make decisions about their care.	Mental Capacity Act policy includes required content and is in date.
CCG SAT; the MCA policy will include actions required of staff where Lasting Powers of Attorneys and Advanced Decisions are in place.	Mental Capacity Act policy includes required content and is in date.
CQC E6.2; how are people supported to make decisions in line with relevant legislation and guidance.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CQC E6.3; how and when is possible lack of mental capacity to make a particular decision assessed and recorded.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
CQC E6.5; when people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; when giving information about a decision it must be accessible, relevant and tailored to their needs.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; record and update information about people's past and present wishes in a way that practitioners from multiple areas can access and update.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; practitioners should tell people about advocacy services as a potential source of support for decision making.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; support people to communicate so that they can take part in decision-making.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; the person assessing mental capacity should record; <ul style="list-style-type: none"> • Practicable steps taken • The outcome of the assessment • If the person lacks capacity, why the practitioner considers this as an uncapacious decision as opposed to an unwise decision. 	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.
NICE NG108; health services should implement a service-wide process for recording best interests decisions.	Evidence from mental capacity audits is managed by the Mental Capacity Act Forum and reported through the Safeguarding Committee.

26.0. References and Bibliography

This policy was drafted with reference to the following:

- Richards, S & Mughal, F. (2018). Working with the Mental Capacity Act (2005), Third Edition, Matrix Training Associates.
- Mental Capacity Act Code of Practice (2007), Department for Constitutional Affairs, London, TSO.

Training Requirements

Training Needs Analysis

Training topic:	Mental Capacity Act
Type of training: (see study leave policy)	<input type="checkbox"/> <u>Mandatory (must be on mandatory training register)</u> <input type="checkbox"/> Role specific <input type="checkbox"/> Personal development
Division(s) to which the training is applicable:	<input type="checkbox"/> <u>Adult Mental Health & Learning Disability Services</u> <input type="checkbox"/> <u>Community Health Services</u> <input type="checkbox"/> Enabling Services <input type="checkbox"/> <u>Families Young People Children</u> <input type="checkbox"/> Hosted Services
Staff groups who require the training:	All employees who have a clinical role within the organisation.
Regularity of Update requirement:	3 yearly.
Who is responsible for delivery of this training?	Trust Safeguarding Team.
Have resources been identified?	Yes.
Has a training plan been agreed?	Yes.
Where will completion of this training be recorded?	<input type="checkbox"/> <u>ULearn</u> <input type="checkbox"/> Other (please specify)
How is this training going to be monitored?	Monthly training flash reports provided by workforce.

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	X
Respond to different needs of different sectors of the population	X
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	X
Work together with others to ensure a seamless service for patients	X
Help keep people healthy and work to reduce health inequalities	X
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	X

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Greg Payne	Lead Practitioner For Adult Safeguarding.

Circulated to the following individuals for comment

Name	Designation
Anne Scott	Deputy Chief Nurse
Neil King	Trust Lead for Safeguarding
Dean Cessford	Senior Safeguarding Practitioner
Zahra Makhany	Senior Safeguarding Practitioner
Laura Belshaw	Deputy Head of Service
Rebecca Colledge	Community Manager
Michelle Churchard	Head of Nursing AMH / LD
Sarah Latham	Lead Nurse Community Hospitals
Sarah Clements	Matron
Caroline Barclay	Nurse Consultant
Lynne Moore	Senior Matron
Louise Short	Inpatient Team Manager
Elizabeth Compton	Senior Matron
Jane Capes	Senior Matron
Claire Armitage	Lead Nurse AMH
Colin Bourne	Clinical Trainer
Debbie Leafe	Clinical Trainer
Christina Brooks	Clinical Governance Manager
Joanne Wilson	Lead Nurse
Deanne Rennie	Deputy Clinical Director
Emma Wallis	Associate Director of Nursing and Professional Practice
Dr Saquib Muhammad	Consultant Psychiatrist
Alison Wheelton	Senior mental Health Act Administrator

Due Regard Screening Template

Section 1	
Name of activity/proposal	Mental Capacity Act Policy.
Date Screening commenced	December 2018.
Directorate / Service carrying out the assessment	Safeguarding Team.
Name and role of person undertaking this Due Regard (Equality Analysis)	Greg Payne.
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS:	
This policy describes the principles & procedures within the Mental Capacity Act and staff roles & responsibilities in applying this within clinical practice.	
OBJECTIVES:	
The policy objective is for Leicestershire Partnership NHS Trust to meet its legal responsibilities as defined in the Mental Capacity Act (2005). Adherence to the legislation will ensure that no differential treatment will occur as a result of a person's protected characteristic.	
Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	This policy applies to people over the age of 16. The application of these policies and procedures will ensure that patients are supported to make their own decisions regardless of their age.
Disability	The application of this policy will ensure that people are supported to make their own decisions regardless of any disability.
Gender reassignment	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Marriage & Civil Partnership	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Pregnancy & Maternity	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Race	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Religion and Belief	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Sex	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Sexual Orientation	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Other equality groups?	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Section 3	

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	X
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Having reviewed the policy it meets the Trust's Equality, Diversity and Human Rights Policy. It does not discriminate on the grounds of any Protected Characteristic and follows clear Human Rights Approach.			
Signed by reviewer/assessor		Date	11 th February 2019
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
Head of Service Signed		Date	

PRIVACY IMPACT ASSESSMENT SCREENING

<p>Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.</p> <p>The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.</p>			
Name of Document:	Mental Capacity Act policy.		
Completed by:	Greg Payne		
Job title:	Lead Practitioner	Date	December 2018
			Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.			No
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.			No
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?			No
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?			No
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.			No
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?			No
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.			No
8. Will the process require you to contact individuals in ways which they may find intrusive?			No
<p>If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786 Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, adoption of a procedural document will not take place until approved by the Head of Data Privacy.</p>			
IG Manager approval name:			
Date of approval:			

Appendix 6

Mental Capacity Act 2005

Form to record an assessment of capacity

Name of person being assessed:

Date:

Time:

The decision required:

On the date and time given above and in relation to the decision the person:
(all practicable steps to help the person with the assessment should be taken by the assessor)

- | | Yes / No |
|--|--------------------------|
| 1. Understood the information relevant to the decision | <input type="checkbox"/> |
| 2. Retained that information | <input type="checkbox"/> |
| 3. Used or weighed the information to make a decision | <input type="checkbox"/> |
| 4. Communicated a decision | <input type="checkbox"/> |

Failure on any one point means the person lacks capacity at this time to make the decision asked of them.

If NO for any point give details of what the person could not do in relation to one or more of the four points and explain what practicable steps were taken to overcome the problem.

I confirm the person lacked capacity to make the decision stated above because of an impairment of, or a disturbance in the functioning of the mind or brain (stated below):

Does the person have the capacity to make the decision? YES

NO

Completed by:

Signature:

Consult: as practicable and appropriate people who have an interest in the welfare of the person. If family or other significant people disagree with the best interests' decision, despite attempts to resolve this, see advice. Consider if the criteria for referral to an Independent Mental Capacity Advocate (IMCA) are met.

Less restrictive: consider if there are less restrictive options in terms of the person's rights and freedom of action.

Can you wait? Consider if the person will have mental capacity sometime in future in relation to the matter. If so, when?

Involve: If reasonably practicable, encourage and permit the person to participate. Evidence how you did this below.

Do not discriminate: do not base the decision solely on age, appearance, behaviour or condition.

Life-sustaining treatment: do not be motivated by a desire to bring about the person's

death if the decision is about life-sustaining treatment.

Available options: carry out an analysis of the benefits and burdens of each of the options identified.

Option 1:

Risks	Benefits

Option 2:

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Option 3:

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Summary: which option has been chosen and why?

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