Mental Capacity Act (2005) Policy

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

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	November 2011	Harmonisation of the Mental Capacity Act guidelines following TCS.
2	April 2014	Reviewed & updated.
3	July 2016	Reviewed & updated.
4	November 2017	Updated in line with MCA improvement plan.
5	December 2018	Policy reviewed and re-written to meet with NICE guidelines NG108.
6	May 2021	Policy reviewed and re-written to make policy more accessible to staff
6.1	August 2021	Policy and Amendments and email address changes
7	Feb-2022	Policy review. Appendices 1 & 5 updates Email addresses to NHS.net
7.1	Apr-2022	Appendix 3 – Best Interest Assessment form wording error amended

For further information contact:

Leicestershire Partnership NHS Trust
Trust Lead for Safeguarding

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 6) of this policy.

Definitions

Mental Capacity	A person's ability to make a **particular** decision at a **particular** time.
Mental Capacity Act 2005 Code of Practice	The Code of Practice provides guidance for people who work with adults who may lack capacity to make decisions. it describes responsibilities when acting for a person who lacks capacity to make a specific decision. All staff should have access to the Code of Practice.
Mental Capacity Act Assessment	A two-stage test underpinned by the first two principles of the MCA. The test establishes whether a person can understand, retain, weigh-up or communicate a specific decision. Inability to complete one of these aspects means that the person lacks capacity.
Causative Nexus	It has been established in case law that in all capacity assessments should evidence that there is a link between the person's inability to make a decision and an impairment of, or a disturbance in the functioning of, the mind or brain,
Best Interests:	If, following a capacity assessment, an individual is found to lack the capacity to make the specific decision; the decision maker should decide what action is in the patient's best interests.
Advance Decision	At a time when a patient has the capacity to make the decision, they may decide that if they lack capacity at some point in the future they do not want to receive specific treatments. If an Advance Decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed ideally by a carer or relative or if this is not appropriate an advocate or independent third party- but not by a member of Trust staff unless there are special circumstances.
Advance Decision to Refuse Treatment	An Advance Decision to Refuse Treatment (ADRT)
Advance Statement	An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding.
Court Appointed Deputy	In certain situations where an individual does not have an LPA but a series of decisions needs to be made the Court of Protection may appoint a deputy who then take on the same functions as an attorney either for a specified period or indefinitely.
Court of Protection	The court that governs the Mental Capacity Act including the DoLS. It can make decisions regarding a person's mental capacity and what is in their best interests.
Independent Mental Capacity Advocate (IMCA)	An independent advocate for people who lack capacity who can support and represent their views as far as possible.

Lasting Power of Attorney (LPA)	A Lasting Power of Attorney is a legal document which gives the attorney (or done as it sometimes called) the authority to make decisions on the patients behalf. There are two types of LPA: Personal Welfare and Property & Affairs. To be valid an LPA must be registered with the Office of the Public Guardian.
Restraint	Section 6(4) of the Act states that someone is using restraint if they: • use force – or threaten to use force – to make someone do something that they are resisting, or • Restrict a person's freedom of movement, whether they are resisting or not.
Balance of probabilities	The standard of proof used in civil law; an outcome is more likely than not based on the evidence available.

1. Purpose of the Policy

1.1 This policy describes how the legal obligations of the Mental Capacity Act (MCA) will be met in Leicestershire Partnership NHS Trust (LPT).

The MCA addresses the duties of staff that provide care for individuals **who are 16 years and over** who may lack capacity to make some or all of their decisions.

2. Summary

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

3. Introduction

3.1 The Mental Capacity Act 2005 (MCA) introduced statutory responsibilities which apply to everyone who is involved in the care, treatment, or support of people over the age of 16 living in England or Wales, who are unable to make all or some decisions for themselves.

3.2 The Mental Capacity Act Code of Practice (2007) is a guide on how to apply the MCA in practice. The Code of Practice ('the Code') provides guidance and information about how the MCA works in practice. **Section 42 of the Act requires that those who make decisions in relation to persons who lack capacity must have regard to the Code.** This duty to have regard to the Code applies to those acting in 'in a professional capacity' and 'receiving remuneration' and consequently will apply to all employees of LPT.

3.3 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out Fundamental Standards. **LPT is required to adhere to these standards.**

The following standards are of a particular relevance to this policy:

- Standard 8 (General)
- Standard 9 (Person Centred Care)
- Standard 10 (Dignity and Respect)
- Standard 11 (Need for Consent)
- Standard 12 (Safe Care and Treatment)
- Standard 12 (Safe Care and Treatment)
- Standard 13 (Safeguarding)
- Standard 17 (Good Governance).

4. Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 Trust Board Sub Committees have the responsibility for ratifying policies and protocols.

4.3 The Executive Safeguarding Lead within LPT is the Chief Nurse. The Executive Lead is responsible for ensuring that a policy is in place to ensure the Trust meets the legislative requirements set out in the Deprivation of Liberty Safeguards (DoLS).

4.4 The Trust Lead for Safeguarding Adults and MCA is responsible for providing expert knowledge and advice on complex areas around the MCA and the DoLS.

4.5 **The Trust Safeguarding Team will:**

- Provide specialist advice regarding the lawful application of MCA at LPT.

4.6 **Managers and Team Leaders**

- To ensure copies of the Mental Capacity Act (2005) Code of Practice and other relevant guidance are available to staff.
- To ensure their staff are appropriately trained regarding mental capacity.
- Ensure that policies and procedures are followed and understood as appropriate to each staff member's role and function; and to appropriately report non-compliance with policy.

4.7 **Clinical Staff**

- Clinical staff must ensure that they follow this policy and follow the procedures that are set out within it.

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment is delivered.

- All Clinical Staff to be familiar with the 5 statutory principles.

- To follow the legislation as set out in Trust Policy & Procedures.

- To have regard to the MCA 2005 Code of Practice.

- To complete Mental Capacity Act & DoLS training as prescribed

4.8 **Mental Capacity Act Link Practitioners**

- Assist with embedding the principles of the MCA within their service.

- Provide feedback where appropriate on use of MCA and DoLS, specific issues and concerns, and training to their Team.

- Promote MCA & DoLS training

- Encourage colleagues to seek advice regarding MCA and DoLS through the LPT MCA and DoLS Advice process:
  lpt.safeguardingduty@nhs.net

5. Decisions

5.1 The MCA works on the basis that capacity is decision specific, which means capacity should be determined in relation to a specific decision a person is being asked to make at a specific time.

5.2 **Excluded Decisions**

The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity. There will be no question of an attorney consenting or the Court of Protection making an order appointing a deputy to provide the requisite consent.

The decisions that can never be made on behalf of someone who lacks capacity are:

- Consenting to marriage or civil partnership.
- Consenting to sexual relations.
- Consenting to a divorce.
- Consenting to the dissolution of a civil partnership.
- Consenting to a child being placed for adoption.
- Consenting to the making of an adoption order.
- Discharging parental responsibility to matters not relating to a child's property.
- Giving consent under the Human Fertilisation and Embryology Act 1990.
- Voting at an election for any public office or referendum.

6. Principles of the Act

6.1 The MCA is underpinned by 5 principles:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The Mental Capacity Act 2005 Code of Practice (2007) provides guidance on how these principles can be applied.

6.2 **Principle 1: Every adult has the right to make their own decisions if they have capacity to do so.**

The law says that all persons over the age of 16 years must be assumed to have capacity unless it is established that they lack capacity. **There is therefore no requirement to routinely assess capacity where it is not in doubt.**

Consent should be sought for any intervention. Valid consent consists of information, capacity to make the decision and that the decision is given without duress/undue influence.

Assuming capacity means that the person is approached with the assumption that they can make the decision. Capacity should be assumed unless properly established that the person lacks capacity and that there is a ‘causative nexus,’ a link between the make the decision and the identified impairment in the diagnostic threshold. It is not possible to simply state that someone has a condition and therefore lacks capacity. It should not be assumed that a person cannot make a decision on the basis of a diagnosis or their presentation.

A lack of capacity cannot be established merely by reference to a person’s age or appearance or condition, or an aspect of their behaviour which might lead other to make unjustified assumptions about their capacity.

For the purposes of the Act, a person lacks capacity in relation to a matter if at a material time he \ she is unable to make a decision for him \ herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Whilst it is essential that health professionals recognise a person’s right to safety and exercise their fundamental duty of care, the Act requires that every effort is made to encourage and support people to make their own decisions. Anybody who claims that an individual lacks capacity should be able to provide proof. The need to be able to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it needs to be made.

6.3 Who should assess capacity?

The individual who makes the decision or intends to undertake the action should assess the patient’s capacity.

When an adult is admitted to hospital it is the responsibility of the in-patient areas to establish a local process to ensure that valid consent to admission is established. Where there is doubt regarding the adult’s capacity to consent to admission the adult’s capacity should be assessed in accordance with the MCA.

Some assessments can be carried out by multidisciplinary team members for example where an inpatient needs to access a different department for their treatment decision making should be jointly made by the referrer and the person undertaking the action, i.e. Radiology/Endoscopy.

The following factors may indicate the need for involvement of a more experienced professional with specialist skills and escalation to the Trusts MCA Lead:

- The gravity of the decision or its consequences.
- Where the person concerned disputes a finding of incapacity.
- Where there is disagreement between family members, carers and\or professionals as to the person's capacity.
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what she\he thinks they want to hear.
- Where the persons capacity to make a particular decision is subject to challenge, either at the time the decision is made or in the future.
- Where there may be legal consequences of a finding of capacity.
- The person concerned is repeatedly making decisions that put him\her at risk, or that result in preventable suffering or damage.

6.4 **Assessment of Capacity**

A capacity assessment can be triggered in one of many ways, following the establishment of a need for a patient to make a specific decision, eg:
a) The person's behaviour / responses suggest they may lack capacity.
b) The person's circumstances suggest they may lack capacity.
c) Someone else has raised concerns over capacity.
d) There have been capacity issues previously.
e) An unwise decision causes concern over capacity.

Capacity assessments should begin from the assumption that a person has capacity, and the member of staff needs to provide evidence of a lack of capacity.

Mental Capacity assessment: The two-stage functional test

A person will be found to be lacking capacity to make a decision if:

Stage 1 is there is an impairment or disturbance of the function of the persons mind or brain - this could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol.

Stage 2 the impairment\disturbance is sufficient that the person lacks capacity to make a particular decision.
To establish stage 2 the following then needs to be considered:

6.5 **Can the person understand information relevant to the decision?**

To demonstrate 'understanding' a person needs to understand the nature of the decision, the reason why it is needed, and to have an element of foresight about the likely consequences of making or not making the decision?

It is not necessary that the patient understands every element of what is being explained to him: What is important is that the patient can understand the 'salient factors', this means that the onus is on staff to identify the specific decision, what information is relevant to that decision, and what the options are that the patient is to choose between. Further, one must not start with a 'blank canvas'.

6.6 **Can they retain that information long enough to make the decision?**
Information need only be held in the mind of the person long enough to make the decision.

6.7 **Can they weigh \ use the information to make a decision?**
This requires the person to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate them one to another. The person must be able to consider and weigh the arguments for and against a proposed action and the likely consequences before making a decision.

6.8 **Can they communicate by any means the decision?**
Any residual communication is sufficient. For example, a person may be able to blink a response to questions. A person would only be unable to communicate if they were unconscious.

6.9 **Concluding an Assessment of Capacity**
If there is a NO answer in any of the above four domains above, then the test indicates that the person lacks capacity in relation to that decision.

The Act requires only a 'reasonable belief' of the assessor that a person lacks capacity in relation to a decision, but Clinicians / practitioners need to be able to identify objective reasons why a person lacks capacity based on the above test.

The capacity assessment should be revisited if the person's condition changes, to ensure it is still relevant and valid.

When assessing capacity, the causative nexus must be incorporated into the assessment and formulation of the written assessment and outcome.

6.10 **Recording of the Capacity Assessments**
Where it is in doubt, a decision maker must record their decision. A record of an assessment may be evidenced either by use of a separate template, within a care plan document, or included in a SystmOne entry record. Any record should be in appropriate detail, commensurate with the complexity of the decision in question. Simple decisions may require only a few lines of analysis, whereas more complex decisions will require a great deal more work and evidence.

6.11 **Principle 2: A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.**

Practitioners assessing mental capacity must help a person make their own decision, before deciding that they are unable to make a decision. It is not necessary for the person to understand every detail of the issue nor is it always necessary for a person to understand all the details. Being able to understand and weigh up the key details relevant to the decision to be made will be sufficient. Different individuals may give different weight to different factors. What is reasonably practicable in one circumstance will be much less so in an emergency. If the decision can be put off until the person has capacity to make it for themselves, it should wait unless it is an emergency.

Decisions should not be made under any form of pressure or duress.

Practitioners can support decision making by ensuring a person-centred approach to assessment. Practitioners should find out from the person how they want to be supported in decision-making.

Consideration should be given to:

- The person's physical and mental health condition.
- The person's communication needs.
- The person's previous experience (or lack of experience) in making decisions.
- The involvement of others and being aware of the possibility that the person may be subject to undue influence, duress or coercion regarding the decision.
- Situational, social and relational factors.
- Cultural, ethnic and religious factors.
- Cognitive (including the person's awareness of their ability to make decisions), emotional and behavioural factors, or those related to symptoms the effects of prescribed drugs or other substances.

Practitioners should maintain professional curiosity and be aware of the possibility of undue influence, duress, or coercion. If such concerns are identified, then the practitioner should discuss concerns with their line manager and if possible, the person. If safeguarding concerns are identified seek advice from lpt.safeguardingduty@nhs.net.

Practitioners should refer to other services (for example Speech and Language Therapy or Clinical Psychology) to enable the person to make their decision when their level of need requires specialist input. This is especially important:

- When the person's needs in relation to decision-making are complex
- If the consequences of the decision would be significant (for example a decision about a highly complex treatment that carries significant risk).

Assessments should be carried out at the most appropriate time of day for the person to maximise their decision-making abilities.

6.12 **Principle 3: A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision.**

All adults have the right to make decisions which others may define as unwise. This can relate to all kinds of daily decisions.

- Non-engagement with an offered service.
- Declining equipment.
- Not following health advice.
- Substance use
- Lifestyle choices

If an adult with capacity makes a decision to refuse care or treatment from an LPT service, then it is their right to make this choice even if it is defined as an "unwise decision." Records should evidence discussion or communication with the adult regarding the benefits and risks of any proposed treatment and any risks posed by the proposed care or treatment being declined.

If a clinician is concerned that an adult is making a decision which poses a risk of significant harm to that adult, then this concern should be clearly discussed with the adult and the outcomes of the discussion documented in the records.

There may be occasions when an adult makes repeated unwise decisions which mean that their capacity to make those decisions is questioned, if this is the case then a capacity assessment should be considered, and advice gained from LPT Safeguarding Team.

6.13 A VARM is arranged when the **adult (anyone 18 or over)** has the capacity to make unwise decisions however they are at risk of imminent significant harm as a result of those decisions. The person either does not engage with services or engagement is not reducing the level of risk and the person remains at risk of significant harm or death. It is essential to note that as well as self-neglecting, the adult must be considered to have a potential need for care and support even if those needs are not being currently met by any agency.

If LPT clinicians believe an adult with care and support needs is at risk of imminent significant harm as a result of capacious decisions then the LPT clinician should contact LPT Safeguarding Team for advice.

A VARM should not be initiated by an LPT staff member until there has been a discussion with LPT Safeguarding Team.

6.14 **Principle 4: Any act done, or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in their best interests.**

Once it appears on the balance of probabilities that the person lacks capacity, the decision maker is required to act in the best interests of the person. The MCA does not specify what is in a person's best interests, nor does it define best interests. The MCA 2005 Code of Practice provides a best interest's checklist which can be used to guide decision makers:

The best interest checklist should be adhered to by decision makers:

- **Encourage participation:** do whatever is possible to permit and encourage the person to take part or improve their ability to take part in making the decision.
- **Identify all relevant circumstances:** try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
- **Find out the person's views:** try to find out the views of the person who lacks capacity, including the persons past and present wishes and feelings; these may have been expressed verbally, in writing, or through behaviour or habits. Any beliefs and values, e.g., religious, cultural, moral or political that would be likely to influence the decision in question, any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.
- **Avoid discrimination:** not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- **Assess whether the person might regain capacity:** consider whether the person is likely to regain capacity (e.g., after receiving medical treatment) if so, can the decision wait until then?
- **If the decision concerns life-sustaining treatment:** not be motivated in anyway by a desire to bring about the persons death, they should not make assumptions about the person's quality of life.
- **Consult others:** if it is appropriate and practical to do so consult other people for their views about the person's best interests to see if they have any information about the person's wishes and feelings, beliefs and values. In particular try to consult everyone previously named by the person as someone to be consulted on either the decision in question or on further issues, anyone engaged in caring for person, close relatives, friends and others who take an interest in the persons welfare, an attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney, any deputy appointed by the Court of Protection to make decisions for the person.

Best interests' decisions must be made from the perspective of the person, not simply what the decision maker considers the best decision.

6.15 **Principle 5: Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the person's rights and freedom of action.**

7. Capacity Disputes

If an assessor is in any doubt after assessment, or their assessment is challenged, it is entirely proper for them to obtain a second opinion from other trained colleagues. Furthermore, assessments can be undertaken by teams of staff if this is found to be appropriate. In all circumstances this should be fully documented in the notes. Where uncertainties or significant dispute continue this should be escalated via your MCA leads.

8. Referral to Independent Mental Capacity Advocacy (IMCA) Service

8.1 The Act places a legal duty on local authorities and the NHS to refer a person to an IMCA in certain circumstances, to support people who lack capacity to make important decisions:

1. Serious medical treatment (starting, withholding, or stopping) or
2. Periods of accommodation in a hospital (28 days or more) or
3. Moving to a care home (8 weeks continuously or more) or
4. Where decisions with serious implications need to be made.
5. IMCAs must be involved when a person aged over 16 and has no family, friends or carers (who might contribute to best-interest decision-making) **AND** Has been evidenced as lacking capacity in relation to one or more important decisions as above.

8.2 The decision maker (usually a health or social care professional) who will make the relevant 'best interests' decision for the person has a legal duty to involve an IMCA in the decision-making process.

- The IMCA's role is to support and represent the person who lacks capacity.
- An IMCA will meet with the person to gather their views and wishes. The IMCA will also gather and evaluate information about the person and the proposed decision and make representations about whether the decision will be in the person's best interests.
- The information provided by an IMCA must be taken into account by a decision maker as part of the process of working out whether a proposed decision is in the person's best interests.
- The IMCA can also challenge the decision made.
  In some safeguarding adult cases, an IMCA may be appointed even where family members or others are available to be consulted.
  If there is a need for urgent treatment or an urgent need for a move to hospital, care home or residential accommodation then an IMCA referral should be made with a follow up call regarding the urgency, but the care or treatment undertaken should not be delayed in urgent circumstances.

8.3 Properly appointed IMCAs have a statutory right of access to records that the record holder believes to be relevant to the decision. Clinicians and practitioners should allow access to files and notes but only to information relevant to the decision. Those responsible for patient / user records should ensure that third-party information and other sensitive information not relevant to the decision remains confidential.

IMCAs are provided in Leicester and Leicestershire by Pohwer. To make an IMCA referral in Leicester, Leicestershire and Rutland:

Leicester City: http://www.pohwer.net/leicester-city

Leicestershire: https://www.pohwer.net/leicestershire

Rutland: https://www.pohwer.net/rutland

Pohwer can be contacted directly for more information and advice: 0300 456 2370 or email pohwer@pohwer.net

For adults who are from a Local Authority outside Leicester, Leicestershire and Rutland contact that Local Authority to establish the IMCA referral process for that area. If a patient is found to be lacking capacity an action may be undertaken, providing that action is in their best interest.

8.4 The person making the decision is referred to as the "Decision Maker" and it is their responsibility to work out what would be in the best interests of the person who lacks capacity. For most day-to-day actions or decisions, the decision maker will be the carer most directly involved with the person at the time. Where the decision involves provision of care and treatment, the most appropriate member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker. Ultimately it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed.

8.5 When working out what is in the best interests, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacks capacity.

8.6 It is up to the decision maker to ensure that they have sufficient information in order to make the decision in the patient's best interests. They must arrange to talk to other professionals involved and the patient's family and friends. In situations where an IMCA is involved they will also receive a report from the IMCA as to what may be in the patient's best interests.

8.7 Best Interests is not purely what would be 'best' medically in terms of prolonging life but must take into account social, emotional and psychological factors as well as anything that the patient may regard as important if they were making the decision themselves.

8.8 When a family member is a primary carer for their relative, they still need to make best interest decisions as defined in the MCA. Clinical staff working with the family member should clearly explain the MCA to the carer/family member to ensure that decisions made are in the best interests of the patient. When there is disagreement regarding best interest decisions and LPT clinicians are concerned this could cause a deterioration in the health of the adult this is a safeguarding issue. An adult has the right to receive prescribed care and treatment to ensure their best outcomes. In such situations LPT staff should contact LPT Safeguarding Team immediately.

9. Consultation

9.1 The Act promotes consultation and requires transparency in decision making processes in order to protect and empower people from random or unsound decision making.

9.2 Family and friends are not decision makers, but they can provide important. information about current and previously expressed wishes, values, beliefs, culture and how different options might impact on them to inform decision makers about the person.

Family and friends may not always agree about what is in the best interests of an individual. If you are the decision maker, you will need to clearly demonstrate in your record keeping that you have made the decision on all available evidence and considered all of the conflicting views. Family and friends must be made aware of the pros and cons of the available options during consultation.

Consultation can be via a meeting for complex decisions or where there are lots of people to consult. Consultation can also be via direct discussions or telephone.

10. Confidentiality

10.1 A best interest decision may require the sharing of information amongst health and social care workers, family and friends. If a person lacks capacity to consent the disclosure information must be based on the determination of the person's best interests.

10.2 The Act places a duty to take into the account the wishes and feelings of others who may have an important role in a person's life but only share as much information as is needed.

10.3 Where an attorney under a Health and Welfare Lasting Power of Attorney (LPA) has been appointed, they will be entitled to access to health and social care information and may also determine if information can be disclosed. Staff must consult with an LPA before sharing any information with a third party.

10.4 Where it is not possible to consult more widely because, for example, urgent treatment is necessary, staff must still act in the patient's best interest.

11. MCA and Safeguarding

11.1 Adults have the right to make decisions regarding all aspects of their life unless a mental capacity assessment indicates that the adult is unable to make a specific decision. Decision makers should then act in the best interests of the adult as described in the MCA 2005 Code of Practice.

11.2 Adults whose health conditions mean that they are unable to make decisions regarding critical day-to day self-care activities such as food intake, personal care and accessing healthcare are especially vulnerable. All of those around them need to ensure that decisions are made in the best interests of the adult as defined by the MCA 2005 Code of Practice.

11.3 If an LPT clinician is concerned that decisions are being made regarding an adult's care and treatment and the principles of the MCA are not being followed, then highlight these concerns to the decision maker and other professionals. It is the duty of the LPT clinician to explain the principles of the MCA. If concerns cannot be resolved through discussion and advice, then the LPT clinician should take action to secure the best interests of the adult.

11.4 If there is a concern that those caring for an adult are not acting in the best interests of the adult the LPT clinician should ensure that they ensure the best interests of the adult. Failure to act in the best interests of an adult who lacks capacity to make a specific decision is a safeguarding concern. If an LPT clinician is concerned that decisions are not made in line with the MCA seek advice from the LPT Safeguarding Team.

11.5 If an adult is unable to maintain their health and wellbeing without the assistance of others and there are concerns that decisions are not being made in the adults best interests a safeguarding adults referral should be made.

12. Children and Young People Aged 16 to 17 Years

12.1 Most of the MCA applies to people aged 16 years and over, there is an overlap with the Children's Act 1989. For the Act to apply to a young person, they must lack capacity to make a particular decision (in line with the Act definition of lack of capacity described previously). In such situations, either this Act or the Children's Act 1989 may apply, depending on the particular circumstances.

12.2 There may also be situations when neither of these Acts provides an appropriate solution. In such cases it may be necessary to look to the powers available under the Mental Health Act 1983, or the High Court's inherent powers to deal with cases involving young people.

12.3 There are provisions in the MCA not available to 16 or 17 year olds. These are:

- Making a Lasting Power of Attorney
- Advance decisions to refuse treatment
- Making a Will

12.4 For complex capacity issues related to 16 and 17 year-olds, staff contact should seek advice via lpt.safeguardingduty@nhs.net.

12.5 Please use the Decision Making Tool to document any assessments of decision making for those under sixteen.

13. IMCA

Serious Medical Treatment

13.1 Where the decision concerns 'serious medical treatment' and there is no-one other than paid staff who are appropriate to consult about the person's best interests, an Independent Mental Capacity Advocate (IMCA) referral is mandatory. Where a Trust clinician is in charge of the treatment, they will be responsible for the referral.

13.2 The 2006 IMCA Regulations define 'serious medical treatment' as:
Treatment which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where: - If a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved.

A decision between a choice of treatments is finely balanced, or what is proposed is likely to have serious consequences for the patient.
The Mental Capacity Act Code at 10.45 suggests some examples by way of a non-definitive list:

- Chemotherapy and surgery for cancer.
- Electro-convulsive therapy.
- Therapeutic sterilisation.
- Major surgery (such as open-heart surgery or brain/neurosurgery).
- Major amputations (for example, loss of an arm or leg).
- Treatments which will result in permanent loss of hearing or sight.
- Withholding or stopping artificial nutrition and hydration, and termination of pregnancy.

13.3 Serious medical treatment does not cover treatment for a mental disorder where the patient is detained under the Mental Health Act. It *does* include Electroconvulsive Therapy (ECT) where the patient is not detained under the MHA.

13.4 Where treatment is urgent, the need to instruct an IMCA should not delay the treatment, but an IMCA should be instructed with minimal delay after the treatment has begun.
Advocacy services are independent of the Trust, and service provision is subject to periodic tender. The identity of the IMCA provider may therefore be

subject to change during the currency of this policy. Check the Trust intranet for the identity of the current provider and appropriate referral forms. http://connect/mental-capacity-act.

Independent Mental Capacity Advocates must be given all reasonably practicable assistance to carry out their function. This includes access to notes that the decision maker considers relevant to the decision.

14. Lasting Power of Attorney

14.1 The MCA allows a person to appoint an Attorney to act on their behalf if they should lose capacity in the future. A Lasting Power of Attorney (LPA) is a formal legal arrangement which allows the Attorney the authority to make specified decisions on behalf of a person who lacks capacity. Existing Enduring Powers of Attorney are also still valid.
An LPA must be registered with the Office of the Public Guardian (OPG) before use.

14.2 Property and Financial LPAs deal with finance, and Health and Welfare LPAs deal with personal care issues (including decisions on medical treatment where the LPA is the decision maker).

14.3 Clinical staff should always ask to see evidence of an LPA for Health and Welfare. A copy of the LPA must be kept in the patients' healthcare records with an alert/flag placed on SystmOne. An LPA can also be verified by an identified hologram on the LPA and unique reference number is intended as proof of validity. The contact details for the Office of the Public Guardian are as follows: https://www.gov.uk/find-someones-attorney-deputy-or-guardian.

An Attorney should always act in the best interests of the person that they represent, **that means representing the views and wishes of the person.** If an LPT clinician is concerned about the actions of an Attorney, they should seek advice from LPT Safeguarding Team.

If necessary, concerns can be raised via the Office of the Public Guardian Safeguarding Office.

15. Court of Protection

15.1 The Court of Protection is the ultimate arbiter for all matters relating to the MCA. The Court has powers of adjudication and will:

- Make declaration about whether a person has the capacity to make a particular decision
- Make declarations about the lawfulness, or otherwise, of an act done or yet to be done, including decisions on serious health care issues and treatment
- Make single orders, individual decisions about the property and financial affairs, or about the health and welfare of a person who lacks capacity.

- The court will have the authority to appoint deputies to make decisions for a person who lacks capacity in complex or disputed cases, and where a single determination is not possible.

16. Advance Decisions

16.1 There is no prescribed form for an advance decision.

Advance decisions can only be made by adults (18 years and older).

Advance decisions can only be made by an adult with capacity to make an advance decision. If there is doubt regarding an adult's ability to make a decision, then a capacity assessment should be completed in relation to the decision to make the advance decision.

16.2 An advance decision should not be made under undue influence or duress.

16.3 Nobody has the legal right to demand specific treatment, either at the time or in advance. So, no-one can insist (either at the time or in advance) on being given treatments that healthcare professionals consider to be clinically unnecessary, futile or inappropriate. But people can make a request or state their wishes and preferences in advance. Healthcare professionals should then consider the request when deciding what is in a patient's best interests (see Appendix 5) if the patient lacks capacity.

17. Advance Decision to Refuse Treatment (ADRT)

17.1 An ADRT must state what specific treatment is refused. An ADRT can be cancelled decision at any time. Advance Decisions cannot be made to refuse 'basic care', defined by the British Medical Association (BMA) as procedures essential to keep the individual comfortable eg. warmth, shelter, personal hygiene, pain relief and the management of distressing symptoms. Advance decisions cannot be used to request a specific type of care treatment or care.

17.2 There is no prescribed format for an Advance Decision however a legally binding Advance Decision would include the following:

1. The nature of the document should be identified with the heading "Advance Decision".
2. The name, address and date of birth of the adult should be stated.
3. The document should be dated.
4. The medical circumstances which would trigger the operation of the Advance Decision, should be specified.
5. The nature of the treatment refused should be set out.
6. A brief expression of the person's values may be useful. This may include a reference to quality of life versus sanctity of life.
7. A request that any doctor or nurse with a conscientious objection to the operation of the Advance Decision can their care to other medical practitioners may be valuable.
8. A revocation of earlier wishes, if relevant.
9. A signature clause, including provision for at least one witness.

To be effective, an Advance Decision must:

- Be available when the relevant circumstances arise.
- Be relevant to the condition in hand.
- Clearly reflect the adult's wishes.

17.3 It is essential to highlight the importance of ensuring the document can be produced when needed. Where possible an advance decision should be recorded in an adult's records with a "flag" attached.

17.4 It is good practice to advise adults to ensure copies of an Advance Decision are with the following:

- GP notes and records.
- any current treating Consultant (where relevant)
- close family members or friends who are likely to be involved in the event of a medical emergency or profound illness.

17.4 Adults should also be advised that they should retain a record of the people who have a copy of the Advance Decision, should they wish to revoke it.

18. Staff Roles and Responsibilities Regarding Advanced Decisions

18.1 An advance decision can be verbal. When planning care and treatment with a patient and an adult expresses a care and treatment preference LPT staff should document the preference in the records stating that this is an advance decision.

18.2 LPT staff should be able to explain to an adult with capacity what an advance decision is and the legal implications.

18.3 Staff should be aware:

- if a patient that they propose to treat has made a previous advance decision.
- valid advance decisions have the same validity for people who lack capacity to make the decision as people with capacity to make the decision.

18.4 Staff must establish whether an advance decision is valid and applicable this includes finding out if the person:

- Has done anything that clearly goes against their advance decision.
- Withdrawn their decision.
- Has subsequently conferred the power to make that decision on an attorney or would have changed their decision if they had known more about the current circumstances.

18.5 If it is established that an advance decision does not exist, is not valid and/or applicable it may still be an expression of the person's wishes, this information can then be used an expression of previous wishes when working out the person's best interests.

18.6 LPT staff must follow a valid advance decision. If staff proceed with treatment against a valid advance decision, they are at risk of a claim for damages of battery or a criminal charge of assault.

18.7 If LPT staff have genuine doubts about the existence, validity or applicability of an advance decision treatment can be provided without incurring liability. Staff will be protected from liability if they are unaware of an advance decision.

LPT staff should seek advice from LPT Safeguarding Team if they require any advice about an advance decision.

19. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

19.1 The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in the event that they do not have capacity to make or express choices at that time. The process aims to respect both patient preferences and clinical judgement in the spirit of shared decision making. Following discussion with the patient, the agreed realistic clinical recommendations are recorded, including a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

19.2 Advance Care Plans are a more comprehensive, holistic plan. ReSPECT should not replace these but to capture a short summary of clinical information and decisions crucial to healthcare professionals attending to the patient in the event of an emergency when the patient may not be capable of expressing their wishes. The decision about the appropriateness of medical treatment ultimately lies with the treating clinician.

19.3 ReSPECT advise that ReSPECT conversations follow the ReSPECT:

- Discussing and reaching a shared understanding of the person's current state of health and how it may change in the foreseeable future,
- Identifying the person's preferences for and goals of care in the event of a future emergency,
- Using that to record an agreed focus of care (either more towards life-sustaining treatments or more towards prioritising comfort over efforts to sustain life),
- Making and recording shared decisions about specific types of care and realistic treatment that they would want considered, or that they would not want, and explaining sensitively advance decisions about treatments that clearly would not work in their situation,
- Making and recording a shared decision about whether or not CPR is recommended.

Please see the LPT ReSPECT Policy

20. Advance Decisions and the Mental Health Act (1983)

20.1 Advance decisions can refuse any kind of treatment, whether for a physical or mental disorder. An advance decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the Mental Health Act 1983, when treatment could be given compulsorily under Part 4 of that Act. If a valid advance-decisions to refuse a specific treatment for a mental disorder clinician are advised that alternative forms of treatment should be considered first. If the refused treatment is deemed necessary, the clinician must document their decision making in line with the Principles of the Mental Health Act 1983.

20.2 Advance decisions to refuse treatment for illnesses or conditions outside of the mental disorder are not affected by the fact that the person is detained in hospital under the Mental Health Act.

20.3 When an adult is detained under the Mental Health Act (1983) any advance decision to refuse treatment for physical disorders (e.g., resuscitation, chemotherapy, certain medications such as antibiotics, PEG feeding) are always legally binding (if valid and applicable) and **MUST** be followed if staff are aware of them.

21. Advanced Decisions to Refuse Treatment, Self-Harm and Suicide

21.1 Clinical staff can find themselves in crisis situations where an adult may have self-harmed or taken an overdose and they are refusing life sustaining treatment. In such situations staff must ensure that there is a valid ADRT in place for the specific treatment required. For this ADRT to be valid it must explicitly state the treatment being refused and it must:

- Be in writing (it can be written by someone else or recorded in healthcare notes).
- Be signed and witnessed, and state clearly that the decision applies even if life is at risk.

21.2 In crisis situations where there is a doubt regarding an adults capacity to make the decision to consent to life saving treatment staff should carry out an assessment of the adults capacity to make the decision to consent to the required life sustaining treatment.

21.2 In cases where an adult deemed to lack the capacity to provide valid consent to life saving treatment and it is not possible to identify or verify a valid ADRT clinical staff should provide the life sustaining treatment.
In *HE V A Hospital,* Munby J stated:
"Where life is at stake, evidence must be scrutinized with special care. Clear and convincing proof must be clearly established by convincing and reliable evidence. If there is doubt, that doubt falls to be resolved in favour of the preservation of life".

22. Suicide, Murder and Manslaughter

Nobody can request procedures that are against the law, such as help with committing suicide. S. 62 of the MCA states that the MCA does not change any of the laws relating to murder, manslaughter or helping someone to commit suicide.

23. Advance Decision to Refuse Electro-Convulsive Therapy (ECT)

23.1 An Advance decision to refuse Electro-Convulsive Therapy (ECT) can be overridden if the Patients is detained under the Mental Health Act 1983 and the ECT is to be given because it is immediately necessary to save the Patients 's life or prevent a serious deterioration in the Patients 's condition (see section 58A(5) and 62 (1A) of the Mental Health Act 1983). Clinicians are advised though that going against an Advance Decision may lead them open to challenge so documentation of the justification for overriding must be clear.

24. Advance Statements

24.1 An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding.
Advance statements are useful if you are worried about losing capacity due to a mental health condition. This is a written statement about what you would like to happen if you lose capacity, such as:

- What treatments you would prefer
- Who you would like to be contacted in a crisis?
- Any spiritual or religious views and requests
- Your food preferences.

25. Advanced Care Plans

25.1 Advance care planning helps people plan for their future care and support needs, including medical treatment.

25.2 Advance statements can include any information a person considers important to their health and care, do not have legal force, but practitioners must consider them carefully when future decisions are being made, and need to be able to justify not adhering to them.

25.3 Advance Care Plans should be offered to everyone who is at risk of losing capacity (through any progressive illness) or who have fluctuating capacity (through any mental illness).

25.4 Clinical staff should document all advance care planning discussions in patient records. If a decision is made to provide care outside of an adult expressed wishes then the rationale for this action should be clearly documented.

26. Joint Crisis Planning

26.1 Practitioners and individuals may wish to consider the use of advance care planning to anyone who has been diagnosed with a mental disorder and has an assessed risk of relapse or deterioration. The offer should be documented and, if the person accepts it, the plan should be recorded in the patient records.

27. Clinical Holds, Restraint and Restriction

27.1 The MCA makes provision for the restraint of an individual providing certain criteria are satisfied.

27.2 Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy. Restraint is not just about ‘hands on’ interventions. Locking a door, telling a person that they cannot do something or go somewhere, giving medication to affect behaviour might have the effect of restraining a person. This applies even if they are not resisting.

27.3 To be lawful under the Act, any restraint must be reasonable, necessary and proportionate to the harm that would come to the person who lacks capacity if the person were not subject to restraint. It must always be for the minimum necessary time, be clearly documented and subject to review. It must always be in the best interests of the person who lacks capacity and be less restrictive of the person’s rights and freedoms.

27.4 Appropriate use of restraint does not in itself amount to a deprivation of a person’s liberty.

27.5 Physical restraint or clinical holds can be used but only as a last resort.

27.6 If any restraint is required a care plan must be completed in line with the defined LPT standards.

27.7 When using restraint as part of their duties clinical staff are protected from liability if they reasonably believe it is necessary to undertake an action which involves restraint, in order to prevent harm to the person lacking capacity **AND** the restraint is **proportionate** to the likelihood and seriousness of that harm. Use of excessive restraint could leave staff and the Trust liable to a range of civil and criminal penalties.

27.8 Care plans should clearly state why the use of restraint or clinical holds is necessary and proportionate to prevent the identified risk of harm. All use of clinical holds or restraint should be documented in the patient’s care plans and records.

27.9 The use of blanket restrictions should be avoided, and care plans should be person-centred and personalised.

27.10 The MCA cannot be used to restrict family contact and relationships. If there are safeguarding concerns regarding contact and relationships where an adult lacks capacity to make decisions regarding relationships advice must immediately be sought from LPT Safeguarding Team.

27.11 Excessive use of restriction or restraint is a safeguarding concern. All concerns related to restraint or restriction should be reported via an eIRF and discussed with LPT Safeguarding Team.

28. Interface between the Care Act (2014) and the MCA

28.1 The Care Act (2014) states that safeguarding duties apply to an adult with care and support needs who as a result of those care and support needs is unable to protect themselves from abuse or neglect. This means that safeguarding duties apply to adults who lack the capacity to maintain their safety and wellbeing. An adult at risk is an adult where safeguarding duties apply.

28.2 Clinical staff and those caring for adults who lack capacity to care for themselves independently should always act in the best interests of an adult. If a carer or family member is not acting in the best interests of the adult, then action must be taken in the best interests of the adult to safeguard the adult.

28.3 If family members or friends are providing care or assistance to an adult that lacks capacity to make a decision, then those family members or friends must act in the best interests of the adult. Examples where a family member or carer may not be acting in the best interests of an adult:

- Failure to bring to appointments.
- Preventing access to healthcare.
- Declining equipment.
- Failing to follow professional advice or best interest decisions.
- Misadministration of medication.

28.4 It is essential that if such concerns are identified they are addressed immediately. In the first instance staff should discuss the concerns with the carers and any other interested parties including other professionals. The family member or friend should be advised that they are legally obliged to act in accordance with the MCA. All discussions should be clearly documented. In some cases, advice and further information of regarding risks may resolve the situation. If resolution cannot be found that the concerns should be escalated through a Safeguarding Adult's referral to the relevant local authority (see LLR Safeguarding Adult's Thresholds and LLR Safeguarding Adults Procedure.
At any stage in the process staff can contact the LPT Safeguarding Team for advice.

28.5 The MCA created two new criminal offences, wilful neglect, or ill treatment of an adult lacking capacity. In all cases where there is a suspicion of an offence, members of staff should alert their line manager immediately and follow the LLR Safeguarding Adults Procedures which includes informing the police. This should be reported on an eIRF.

29. Coercion and Undue Influence

29.1 In some cases, an adult may fall outside of the scope of the MCA because they do not fulfil Stage 1 of the assessment of capacity (an impairment of mind or brain) OR they have an impairment of mind or brain, but they are assessed as having the capacity to make a decision. Decision making capacity can be impaired by the coercion or undue influence of a third-party.

29.2 If an adult is at risk of harm as a result of coercion or undue influence, then the LPT clinician should seek advice from their manager and if required the LPT Safeguarding Team: lpt.safeguardingduty@nhs.net

30.0 MCA and DoLS Advice

StaffNet provides information on MCA and DoLS.

All staff should ensure that they have access to the MCA 2005 Code of Practice.

In the first instance all MCA and DoLS advice requests should come to: lpt.safeguardingduty@nhs.net

Legal advice regarding MCA or DoLS can only be requested by the LPT Safeguarding Team with agreement from the Lead Practitioner for Safeguarding Adults and MCA.

For LPT staff reading this policy the following LPT Trust policies should also be considered:

- Consent to Treatment Policy
- Deprivation of Liberty Safeguards
- Incident Reporting Policies
- Risk management Strategy and Policies
- Clinical Care Policies
- Safeguarding Children and Adults
- Mental Health Act Policies
- The above list is not intended to be exhaustive.

31. Monitoring Compliance and Effectiveness

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements.

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Relevant staff have attended mandatory MCA training as identified in this policy	Training records	Workforce training reports	LPT Directorate Level Safeguarding Committees	Monthly

32.0 References

Department of Constitutional Affairs (2005) Mental Capacity Act Code of Practice (2007). Stationery Office. London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

Department of Education and Skills (2004) The Children Act 2004, London: The Office of Public Sector Information. https://www.legislation.gov.uk/ukpga/2004/31/contents

Department of Health (2015) Mental Health Act 1983; Code of Practice https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf

Department of Health (2014) Positive & Proactive Care;Reducing the need for restrictive intervention https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300291/JRA_DoH_Guidance_on_RH_Summary_web_accessible.pdf

Department of Health (2012) Health & Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

National Institute for Health & Social Care (2018) Decision-making and mental capacity NICE Guidance [NG108] https://www.nice.org.uk/guidance/ng108

Resus Council: ReSPECT : https://www.resus.org.uk/respect/respect-healthcare-professionals

The National Council for Palliative Care. Advance Decisions to Refuse Treatment; A Guide for Health and Social Care Professionals. Available at: http://www.adrtnhs.co.uk/

Case Law

HE V A Hospital https://www.bailii.org/ew/cases/EWHC/Fam/2003/1017.html

LPT Policy and Procedures

Consent to Treatment https://www.leicspart.nhs.uk/wp-content/uploads/2020/02/Consent-to-Examination-or-Treatment-Policy-exp-Feb-23.pdf

Covert Medication Policy https://www.leicspart.nhs.uk/wp-content/uploads/2020/04/Covert-Administration-of-Medicines-Policy-exp-Apr-22.pdf

Medication Management https://www.leicspart.nhs.uk/wp-content/uploads/2020/04/Covert-Administration-of-Medicines-Policy-exp-Apr-22.pdf

Appendix 1

A specific decision needs to be taken by a person (aged 16 years or over) who has an impairment of, or disturbance in the functioning of the brain or mind & there is a question over their capacity.

Capacity assessment of the person's ability to make a particular decision at the time it needs to be made. Although it should be assumed that everyone has capacity until assessed otherwise, a decision to undertake an assessment may be triggered because:

- The person's behaviour or circumstances suggest they may lack capacity
- Someone else has raised concerns
- There have been capacity issues previously.

The 2 stage assessment should be documented on the clinical system.

Duress and coercion may affect a person's judgement & ability to make a decision.

If there is a concern or the case is complex, contact LPT Safeguarding Team: lpt.safeguardingduty@nhs.net

Person lacks capacity to make a particular decision

Does this person have an Advanced Decision (AD) which refers to this decision to be made?

OR

Does this person have a registered Enduring or Lasting Power of Attorney (EPA / LPA) or court appointed deputy who has authority to make this decision?

Check registration via Office and Public Guardian:

www.gov.uk/goverment/publications/search-publicguardian-registers

YES → Follow the direction of the Advanced Decision (AD) or Lasting Power of Attorney (LPA).

An LPA with Authority to give or refuse treatment may override an AD if made after the AD.

NO →

Person has capacity to make the decision.

Person makes the decision even if this is considered to be an unwise decision.

Consider: Does the decision relate to any of the following?

- An NHS Body is proposing to provide serious medical treatment, *or*
- NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or care home, and the person will stay in hospital longer that 28 days, or they will stay in the care home for more than 8 weeks, **AND** the person has no one else to support them (other than paid staff).

YES → An IMCA must be instructed and consulted please contact the relevant local authority.

NO → Consult with the person who is able to give an opinion about what is best for them (this is likely to be close friends & family). Consider whether the decision concerns:

- Care reviews, where no-one else is available to be consulted, or
- Safeguarding adult cases, whether or not family, friends or others are involved.

Use the **LPT best interest** form to support the best interest decision making process OR arrange a **best interest meeting** if Best interests' decisions must be made from the perspective of the person, not simply what the decision maker considers the best decision.

Decision made & documentation recorded in notes. Where there is a disagreement about what is in a person's best interests this should be addressed locally but if all other means to resolve the dispute fail, the Court of Protection might need to rule on the person's best interests. Seek advice from the Trust Safeguarding Team: lpt.safeguardingduty@nhs.net

Dec 2021– V4

Appendix 2

MCA Assessment

A mental capacity assessment should be completed when there is doubt that an adult is able to make a given decision. This assessment should be completed by the decision maker. All parts will need to be completed. If you require advice regarding a Mental Capacity Assessment e-mail lpt.safeguardingduty@nhs.net

Name	
Date of Birth	
NHS Number	
Name of assessor	
Job Title	
Date of assessment	

Summarise the decision required

What has caused the assessor to doubt the adult's capacity to make the decision?	
The persons behaviour suggests they may lack capacity	
The person's circumstances suggest they may lack capacity	
Someone else has raised concerns	
There have been capacity issues previously	
Other (please state details)	

Stage 1 – Does the patient have an impairment of or disturbance in the functioning of the brain or mind?

Yes ☐ No ☐ (if the answer is **NO** then capacity is not the issue) If **YES** record nature of disturbance and move to Stage 2.

Neurological Disorder ☐

Learning Disability ☐

Mental Disorder ☐

Dementia ☐

Stroke ☐

Head Injury ☐

Delirium, Unconsciousness ☐

Substances Use ☐

Other ☐

Additional details

Stage 2

Please indicate the key information the person will need to understand and use to make the decision.

What steps have been taken to help the person make the decision?

Understanding - Does the person understand the information relevant to the decision?	**Yes**	**No**

Retain – Can the person use or weigh the relevant information to make a decision?	**Yes**	**No**

Use / Weigh – Can the person use or weigh the relevant information to make a decision?	**Yes**	**No**

Communication – Can the person communicate their decision? This could be talking, using sign language or other means.	**Yes**	**No**

If the person is unable to understand or retain or weigh-up or communicate the decision please record evidence of the link between the impairment of or disturbance in the functioning of the brain or mind and the inability to make the required decision?

Based on the information provided and gathered I therefore have reasonable belief that the patient **has / has not** got capacity to make this decision (Please delete as appropriate)	
Assessment completed by	
Signature	
Date and time completed	

Appendix 3

Best Interest Assessment Form

Best Interests Assessment Form	
To use this form the person must be aged 16+ and an assessment of mental capacity under the Mental Capacity Act)2005) must show they lack capacity to make the decision in question.	
Name	
Date of Birth	
NHS Number	
Name of assessor	
Job Title	
Best Interests decision required	
Is there a valid Lasting Power of Attorney? (you must see written proof).	
Yes:	**Consult with the LPA and ensure that the LPA decision is clearly recorded in the records.**
No	Continue with the checklist
Is there a Court Appointed Deputy or Court of Protection order with authority over the decision?	
Yes	Clarify details and seek advice from manager or LPT Safeguarding Team
No:	Continue with the checklist.
To make a best interest decision for another person you must consider the following Best Interest Checklist as defined below.	
The relevant information: consider all the relevant circumstances (clinical opinion, history, assessed needs, risks, social factors, emotional factors, available options, etc.)	
The person: consider the person's reasonably ascertainable past and present wishes, feelings, statements, beliefs and values and any other factors the person would consider if able to do so.	
Consult: as practicable and appropriate people who have an interest in the welfare of the person. Consider if the criteria for referral to an Independent Mental Capacity Advocate (IMCA) are met. If family or other significant people disagree with the best interests' decision, despite attempts to resolve this seek advice from LPT Safeguarding Team.	

Less restrictive: consider if there are less restrictive options in terms of the person’s rights and freedom of action, but a less restrictive option must ensure that the person is safe.
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:	
Benefits	Burdens
Option 2:	
Benefits	Burdens
Option 3:	
Benefits	Burdens
Summary: which option has been chosen and why?	

Completed by	
Signature	
Date and time completed	

Appendix 4

My Advanced Statement

Part 1 – Personal Information

Name: Date of Birth:

Address: Contact Number:

Please indicate whether you would like this person to hold a copy of this document.

	Yes	No
Consultant	☐	☐
GP	☐	☐
Advocate	☐	☐
Care Co-ordinator	☐	☐
Family member(s) or friend(s)	☐	☐

	Yes	No
I would like this statement to be included in my record.	☐	☐
I would like a copy of this statement to be held on a confidential database, in case of loss or damage.	☐	☐

Part 2 – Care and Treatment

a. My wishes for my care and treatment are as follows:
What I want:

What I do not want:

b. In previous situations, this has worked well for me:

c. In previous situation, this has not worked well for me:

d. My individual need whilst being cared for are as follows:

e. Who I would name as an advocate:

f. Where I would prefer to receive care and treatment:

Part 3 – Personal Care and Social Statement

Family and Friends

a. Who can/should be informed of my situation:

b. Who cannot/should not be informed of my situation

Dependants

c. I would like to make arrangements for those that I care for as follows:

Pets

d. I would like to make arrangements for the care of my pet(s) as follows:

Housing/Home

e. I would like to make the following arrangements for my housing/home care needs:

Finances

f. I would like the following arrangement to be made for my finances:

Part 4 – Open Statement

Please use this space to include any information or individual needs, which have not been included in previous parts of the document.

Part 5 – Declaration

I, ___________________________________ declare that this document has been completed by myself and/or in accordance with my wishes, at a time when I retain capacity to:

Understand information about treatment options available to me.

Make informed choices and decisions regarding my treatment.

In the event that I become incapable of expressing my choices due to mental health difficulties, it is my wish that this document is referred to as an expression of my choices regarding my mental health care. It is my wish that this document precedes all other ways of ascertaining my intent.

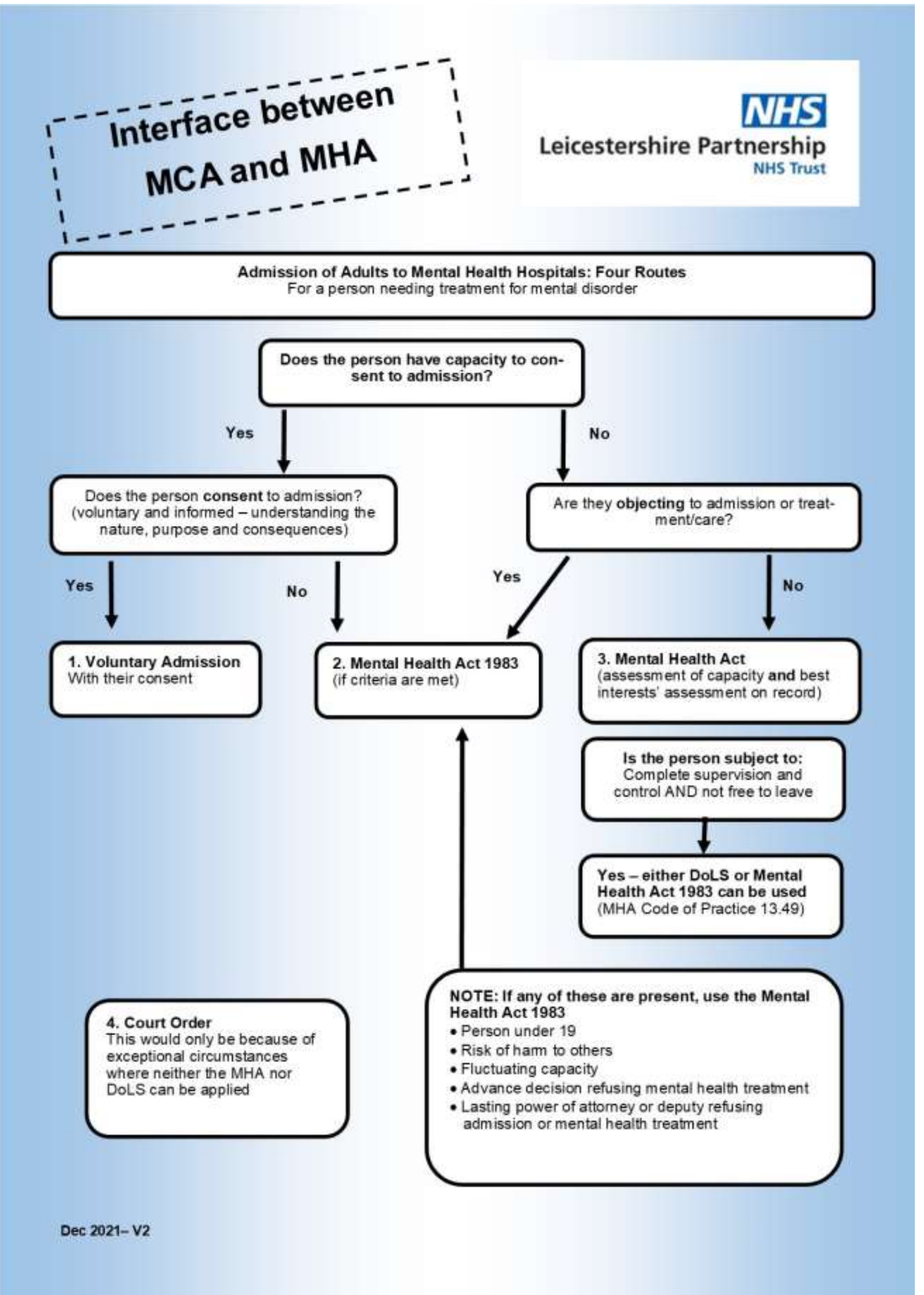
I present this document in the understanding that it will be followed where possible, and in the event that the choices expressed in this document are not followed, I will be provided with a full explanation when I regain capacity.

Signed: Date:

Witness 1
Name:
Address:
Signature:
Date:

Witness 2
Name:
Address:
Signature:
Date:

Appendix 5



Appendix 6

Competency Decision Making Tool

Competency assessment (for children aged 15 and under)

Please note anyone aged 16 and over should be assumed to have capacity to make decisions unless they are assessed to lack capacity (see mental capacity act policy and assessment)

Any child under the age of 16 who is to make their own decision in a specific area should not be assumed to be competent and an assessment should be carried out to ensure their understanding, maturity and ability to use or weigh the information.

This assessment should be completed for any decision the child expresses a wish to make the decision themselves

Persons Name	
Date of Birth	
NHS Number	
Name of Assessor	
Job Title	
Date	

What is the decision that needs to be made?

What practicable steps have been taken to provide the child with the relevant information- consider what are the salient points, the available choices, has the information been given in age appropriate language, including their individual needs

Is the child willing to make a choice (including the choice that someone else (e.g. a parent) can make the decision)?

Does the child have the ability to understand that there is a choice and that choices have consequences? Consider their maturity in understanding the decision within this.

Does the child have an understanding of the nature and purpose of the proposed intervention and its risks and side effects?

What steps have been taken to ensure the child is free from undue pressure?

I therefore have a reasonable belief that the patient **has/has not** got the required level of competency for this specific decision
(Please delete as appropriate)

Assessment completed by	
Date and time completed	
Second opinion- if required	

Due Regard Screening Template **Appendix 7**

Section 1	
Name of activity/proposal	Mental Capacity Act Policy.
Date Screening commenced	May 2021
Directorate / Service carrying out the assessment	LPT Safeguarding Team.
Name and role of person undertaking this Due Regard (Equality Analysis)	Alison Taylor-Prow
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy describes the principles and 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**	19th May 2021
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	19th May 2021

Appendix 8

PRIVACY IMPACT ASSESSMENT SCREENING

<table>
<tr><td colspan="5">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.

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.</td></tr>
<tr><td>Name of Document:</td><td colspan="4">Mental Capacity Act Policy</td></tr>
<tr><td>Completed by:</td><td colspan="4">Alison Taylor-Prow</td></tr>
<tr><td>Job title:</td><td>Lead Practitioner for Safeguarding</td><td>Date</td><td colspan="2">May 2021</td></tr>
<tr><td colspan="4"></td><td>Yes / No</td></tr>
<tr><td colspan="4">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.</td><td>No</td></tr>
<tr><td colspan="4">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.</td><td>No</td></tr>
<tr><td colspan="4">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?</td><td>No</td></tr>
<tr><td colspan="4">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?</td><td>No</td></tr>
<tr><td colspan="4">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.</td><td>No</td></tr>
<tr><td colspan="4">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?</td><td>No</td></tr>
<tr><td colspan="4">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.</td><td>No</td></tr>
<tr><td colspan="4">8. Will the process require you to contact individuals in ways which they may find intrusive?</td><td>No</td></tr>
<tr><td colspan="5">If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via
lpt.dataprivacy@nhs.net
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</td></tr>
<tr><td colspan="2">Data Privacy approval name:</td><td colspan="3"></td></tr>
<tr><td colspan="2">Date of approval:</td><td colspan="3"></td></tr>
</table>

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

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