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
8	February 2024	Policy reviewed and updated to make the policy easier to read and definitions expanded to create user-friendly version as stand-alone document
9	October 2024	7.3 - Stage 2 Test updated. General grammar & structure updated.

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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 (Appendix 7) 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.

Definitions

Term	Definition
Advance Decision for life-sustaining treatment	An advance decision to refuse life-sustaining treatment communicates patient's wishes to health professionals and is a legally binding document. The advance decision is made at a time when a patient has capacity and can only be made by those aged over 18 years old. An advance decision must be a clear, written statement and signed in the presence of a witness. Health professionals must provide life-sustaining treatment unless they are satisfied that a valid and applicable advance decision exists. Emergency treatment should not be delayed in order to identify an advance decision. If healthcare professionals have genuine doubts and are not 'satisfied' about the existence, validity and applicability of the advance decision, life-sustaining treatment can be provided without incurring liability. Healthcare professionals will be protected from liability for failing to provide treatment if they 'reasonably believe' that an advance decision exists.
Advance Decision to Refuse Treatment (ADRT) Often termed "living will"	An ADRT is a legally binding statement (written/verbal) which can be made in advance to refuse treatment but no-one has the legal right to demand specific treatment, either at the time or in advance. Healthcare professionals should consider the ADRT when deciding what is in a patient's best interests if the patient lacks capacity for a specific treatment decision. To make an advance decision a person must be over 18 years and have mental capacity to make the advance decision.
Advance Statement	An advance statement allows a person to make general statements, describing their wishes and preferences about future care should they be unable to make or communicate a decision or express their preferences at the time. It is not legally binding. To make an advance decision a person must be over 16 years and have mental capacity to make the advance statement.
Balance of probabilities	The standard of proof used in civil law; an outcome is more likely than not based on the evidence available.

Best Interests	If an individual is found to lack the capacity to make a specific decision; a decision should be made on their behalf and in their best interest. The best interest decision should not only factor medical needs but should also account for social, emotional and psychological factors. This decision should take account of any previous wishes and feelings of the person who lacks capacity.
Care Act 2014	A law which sets out the duties of the local authority to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. The Act creates a single, consistent route to establishing an entitlement to public care and support for all adults with needs for care and support and unpaid carers. The Act sets out a legal duty for an adult's 'eligible needs' to be met by the local authority, subject to their financial circumstances, in line with other agencies.
Causative Nexus	Once you have identified an impairment or disturbance in the functioning of the mind or brain, it is important to decide whether the inability to make the decision is because of this impairment. This was defined in the case of; PC and NC v City of York Council [2013] EWCA Civ 478. https://www.mentalhealthlaw.co.uk/PC_v_City_of_York_Council_(2013)_EWCA_Civ_478
Children Act 1989	A law relating to children and those with parental responsibility for children where children are those aged under the age of 18 years.
Court of Protection & Court Appointed Deputy	**The Court of Protection** deals with decision-making for adults (and children in a few cases) and can: • make declarations, decisions and orders on financial and welfare matters affecting people who lack, or are alleged to lack, capacity (the lack of capacity must relate to the particular issue being presented to the court) • appoint deputies to make decisions for people who lack capacity to make those decisions • remove deputies or attorneys who act inappropriately For cases about serious or major decisions concerning medical treatment the NHS Trust (please email lpt.safeguardingduty@nhs.uk) or other organisation responsible for the patient's care will usually make the

	application. If the local authority are concerned about a decision that affects the welfare of a person who lacks capacity, they should make the application. In certain situations where an individual lacks capacity and does not have a Lasting Power of Attorney (LPA) the Court of Protection may appoint a **Court Appointed Deputy** who then takes on the same functions as an attorney either for a specified period or indefinitely. Multiple Deputy's may be appointed in certain circumstances.
Decision-Maker	A range of multi-agency decision-makers may be involved with a person who lacks capacity. Where the decision involves the provision of medical treatment the doctor/healthcare professional responsible for carrying out the treatment is the decision-maker. If a Lasting Power of Attorney (LPA) has been registered the Attorney will be the decision-maker for decisions within the scope of their authority as long as the decision is in the person's best interest. The decision-maker should consult all relevant parties involved including family and informal carers before making a final decision.
Deprivation of Liberty Safeguards (DoLS)	The Deprivation of Liberty Safeguards (DoLS) 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 and treatment to keep them safe from harm.
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out Fundamental 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 13 (Safeguarding) • Standard 17 (Good Governance)

Independent Mental Capacity Advocate (IMCA)	IMCAs are a legal safeguard for people who lack capacity to make specific important decisions. They are usually appointed when there is no family member or friend who is able to represent the person or if they are not thought to be acting in the best interest of the person who lacks capacity. IMCAs are provided in Leicester, Leicestershire and Rutland by Pohwer. See section 10.0 of LPT MCA (2005) Policy for contact details.
Lasting Power of Attorney (LPA)	A Lasting Power of Attorney is a legal document which gives the attorney 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. LPA replaced Enduring Power of Attorney. Pre-Existing Enduring Power of Attorney are still valid.
Mental Capacity	A person's ability to make a specific decision for themselves at the time the specific decision needs to be made. Mental capacity can fluctuate.
Mental Capacity Act 2005 Assessment	A two-stage test underpinned by the first two principles of the Mental Capacity Act (MCA). The test establishes whether a person can understand, retain, weigh-up and communicate a specific decision. Inability to complete one of these aspects means that the person lacks capacity for that specific decision at that specific time.
Mental Capacity Act 2005 Code of Practice	The Code of Practice provides guidance for people who work with people aged 16 years and over who may lack capacity to make decisions. For 16 and 17 year olds: see section 12 of LPT MCA (2005) Policy. The Code of Practice describes responsibilities for those acting on behalf of a person who lacks capacity to make a specific decision. All staff should have access to the Code of Practice. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
Mental Health Act (1983) [Amended 2007]	A law which sets out the compulsory care and treatment of patients with mental health illness. In particular, it covers detention in hospital for mental health treatment.

Office of the Public Guardian (OPG)	The Public Guardian is an officer established under the Mental Capacity Act 2005. The Office of the Public Guardian will keep a register of, and supervise deputies, those with Lasting Power of Attorney and Enduring Power of Attorney. The OPG will check on what attorneys are doing and investigate any complaints.
Reasonable belief	The Mental Capacity Act says that an assessor must have a reasonable belief that their assessment of someone's capacity is correct before they can act on their behalf. This means that any other reasonable person would come to a similar conclusion in the same circumstances.
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.
Two stage functional test	This is a test to assess whether a person has capacity to make a specific decision at the time in which it needs to be made. Stage 1 – Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain? Stage 2 – Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? For more information, please see section 7.3 of the MCA Policy.
5 principles of the act	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 decide 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 decide 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

1. Purpose of the Policy

1.1 This policy explains how the legal obligations of the Mental Capacity Act 2005 (MCA) will be met by 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 a specific decision, at a specific time, for themselves.

2. Summary

2.1 This policy describes the principles and procedures within the Mental Capacity Act 2005 and details the roles and responsibilities for all LPT staff when applying the Act 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 a specific decision at a specific time for themselves.

3.2 The Mental Capacity Act 2005 Code of Practice (2007) ('the Code') provides guidance to anyone who is working with and/or caring for adults who may lack capacity to make specific decisions. It describes their responsibilities when acting or making decisions on behalf of someone who may lack capacity to make a specific decision at a specific time.

Section 42 of the Mental Capacity Act requires that those who make decisions in relation to persons who lack capacity must have regard to the Code of Practice. This duty applies to those acting '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 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 Director of Nursing & Allied Health Professionals. The Executive Lead is responsible for ensuring that a policy is in place and ensuring the Trust meets the legislative requirements set out in the application of the Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS).

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

4.5 **The Trust Safeguarding Team** will provide specialist advice regarding the lawful application of the MCA by LPT staff.

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 including the MCA and how to undertake mental capacity assessments where required. Training will be accessed via U-learn and touring MCA Workshops.
- To 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 the policy.

4.7 **Clinical Staff**

- Clinical staff must ensure that they follow this policy and adhere to 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. If there is a question over a patient's mental capacity to consent then a capacity assessment should be undertaken. Further information on assessments can be found in section 7.
- All Clinical Staff should be familiar with the 5 statutory principles (outlined in section 6.1 of this Policy).
- 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 2005 & DoLS training as prescribed.

4.8 **Link Practitioners**

- Assist with embedding the principles of the MCA within their service.
- Provide support and guidance when required on the use of the MCA and DoLS.

- Support with and raise any specific issues and concerns and provide training to their team.
- Promote MCA & DoLS training.
- Encourage colleagues to seek advice regarding MCA and DoLS through the LPT Safeguarding Team at lpt.safeguardingduty@nhs.net or call ☎ 0116 295 8977

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. **It is not possible for an individual to generally 'lack capacity'.**

5.2 **Excluded Decisions**

The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity for that specific decision. There will be no option for an Attorney or decision-maker to consent on their behalf, nor for the Court of Protection to make an order appointing a deputy to provide 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 **Principle 1: Every adult has the right to make their own decisions if they have capacity to do so.**

6.1.1 The Act states that all persons over the age of 16 years must be assumed to have capacity unless it is established that they lack capacity for a specific decision at a specific time. **There is therefore no requirement to routinely assess capacity where it is not in doubt.**

Consent should be sought for any intervention. Consent to treatment means a person must give permission before they receive any type of medical treatment, test, or examination. For consent to be valid, it must be voluntary and informed, and the individual must have the capacity to make the decision at the time that the decision needs to be made without duress/undue influence.

Capacity should always initially be assumed, i.e. the person should be approached with the assumption that they can make the required decision unless it is properly established that the person lacks capacity for the specific decision and that there is a ‘causative nexus’. This is a link between the ability to 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 others to make unjustified assumptions about their capacity.

The MCA explains that a person lacks capacity in relation to a specific decision at a specific time if he/she is unable to make the decision for him / herself because of an impairment of, or a disturbance in the functioning of, the mind or brain (whether temporary or permanent).

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.

Case Law

AMDC V AG & ANOR [2020]: ‘AN EXPERT REPORT SHOULD NOT ONLY STATE THE EXPERT’S OPINIONS, BUT ALSO EXPLAIN THE BASIS OF EACH OPINION. THE COURT IS UNLIKELY TO GIVE WEIGHT TO AN OPINION UNLESS IT KNOWS ON WHAT EVIDENCE IT WAS BASED AND WHAT REASONING LED TO IT BEING FORMED’

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.

6.2 **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.**

6.2.1 This principle aims to stop people being automatically labelled as ‘lacking capacity’ and encourages individuals’ to play as big a role as possible in decision-making and prevent unnecessary intervention in their lives.

Case Law

CH V A METROPOLITAN COUNCIL (2017): ‘IDENTIFIES THE IMPORTANCE OF TAKING ALL NECESSARY PRACTICAL STEPS TO SUPPORT P IN GAINING THE REQUITE CAPACITY’.

It is therefore important to do everything practical, to help individual's make decisions for themselves before concluding that they lack the capacity to do so. Remember it is only possible to lack capacity for specific decisions at the specific time in which the decision needs to be made, and there is no such thing as generally lacking capacity.

6.2.2 Practitioners can support decision-making by using a person-centred approach and 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 the LPT Safeguarding Team.
  lpt.safeguardingduty@nhs.net or call ☎ 0116 295 8977

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.

6.3 **Principle 3: A person is not to be treated as unable to make a decision merely because they make an unwise decision.**

6.3.1 Everybody has their own values, beliefs, preferences and attitudes and 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

Case Study

LB V WANDSWORTH V M & ORS (2017): "THERE IS A SPACE BETWEEN AN UNWISE DECISION AND ONE WHICH AN INDIVIDUAL DOES NOT HAVE THE MENTAL CAPACITY TO TAKE AND... IT IS IMPORTANT TO RESPECT THAT SPACE, AND TO ENSURE THAT IT IS PRESERVED, FOR IT IS WITHIN THAT SPACE THAT AN INDIVIDUAL'S AUTONOMY OPERATES".

LPT service, then it is their right to make this choice even if it is seen 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 someone 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. The clinician should also seek advice from LPT Safeguarding Team:
lpt.safeguardingduty@nhs.net or call ☎ 0116 295 8977.

There may be occasions when a person 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.

6.3.2 A VARM (Vulnerable Adult Risk Management) meeting is arranged when an adult (anyone 18 or over) has the capacity to make unwise decisions but is at risk of imminent significant harm because 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 the adult must be considered to have potential care and support needs even if those needs are not being currently met by any agency in line with the Care Act 2014.

If LPT clinicians believe an adult with care and support needs is at risk of imminent significant harm because of their decisions, then the LPT clinician should contact LPT Safeguarding Team for advice:
lpt.safeguardingduty@nhs.net or call ☎ 0116 295 8977

A VARM does not need to be initiated only with prior discussion and permission of the LPT Safeguarding Team. Any LPT staff member may commence a VARM, and support is available from the LPT Safeguarding Team if required.

6.4 **Principle 4: An act done, or decision made, under the Mental Capacity Act 2005, for or on behalf of a person who lacks capacity must be done, or made, in their best interests.**

It is not possible to give a single description of what ‘best interests’ are as they will depend on individual circumstances. However, section 4 of MCA sets out a checklist to follow to determine what is in the best interests of a person who lacks capacity to make a decision each time someone acts or makes a decision on their behalf.

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:** Do not make assumptions about someone’s best interests simply based on 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:** Do 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.
- **Avoid restricting the person’s rights:** see if there are other options that may be less restrictive of the individual’s rights.
- **Take all of this into account:** weigh up all these factors to work out what is in the person’s best interests.

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

6.5 **Principle 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.**

Before a decision is made on behalf of an individual who has been found to lack the capacity to make that decision themselves, the decision-maker must question if they can do something else that would interfere less with the person's basic rights and freedoms. This includes considering whether there is a need to act or decide at all. However, the final decision must always allow the original purpose of the decision to be achieved, and all decisions must be made in the best interests of the person. Sometimes this may mean that the decision made is not the least restrictive but is in their best interests. Weigh up whether delay (in the hope of regaining capacity might aslso be safe and in their best interest.

Codes of Practice s5

ACTS IN CONNECTION WITH CARE OR TREATMENT

(1) IF A PERSON ("LPT STAFF") DOES AN ACT IN CONNECTION WITH THE CARE OR TREATMENT OF ANOTHER PERSON ("PATIENT"), THE ACT IS ONE TO WHICH THIS SECTION APPLIES IF—

(A) BEFORE DOING THE ACT, LPT TAKES REASONABLE STEPS TO ESTABLISH WHETHER PATIENT LACKS CAPACITY IN RELATION TO THE MATTER IN QUESTION, AND

(B)WHEN DOING THE ACT, LPT REASONABLY BELIEVES—

(I)THAT PATIENT LACKS CAPACITY IN RELATION TO THE MATTER, AND

(II)THAT IT WILL BE IN PATIENTS'S BEST INTERESTS FOR THE ACT TO BE DONE.

(2)D DOES NOT INCUR ANY LIABILITY IN RELATION TO THE ACT THAT HE WOULD NOT HAVE INCURRED IF PATIENT—

(A) HAD HAD CAPACITY TO CONSENT IN RELATION TO THE MATTER, AND

(B) HAD CONSENTED TO LPT DOING THE ACT.

(3) NOTHING IN THIS SECTION EXCLUDES A PERSON'S CIVIL LIABILITY FOR LOSS OR DAMAGE, OR HIS CRIMINAL LIABILITY, RESULTING FROM HIS NEGLIGENCE IN DOING THE ACT.

(4) NOTHING IN THIS SECTION AFFECTS THE OPERATION OF SECTIONS 24 TO 26 (ADVANCE DECISIONS TO REFUSE TREATMENT).

7 Mental Capacity Assessments [see Appendix]

A Mental Capacity Assessment is a test to determine whether an individual has the capacity to make a specific decision at the time in which the decision needs to be made. This could be small, day-to-day decisions such as what to wear, or larger, potentially life-changing decisions around health, housing or finances.

7.1 **Assessment of Capacity**

There are several reasons why an individual's capacity may be called into question to make a specific decision at a specific time. For example:

a) The person's behaviour / responses cause doubt as to whether they have capacity to make a specific decision.

b) The person's circumstances cause doubt as to whether they have capacity to make a specific decision.

c) Someone else has raised concerns over the individual's capacity.

d) The individual has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.

e) An unwise decision causes concern over capacity.

Capacity assessments should always begin with the assumption that a person has capacity, and the member of staff needs to provide evidence of a lack of capacity for the specific decision that needs to be made at the specific time in which it is required.

7.2 **Who should assess capacity?**

There is no set person who should assess an individual's capacity and the relevant person will depend on the specific decision that needs to be made at the specific time. For example, a care worker may need to assess an individual's capacity to agree to being bathed, or a district nurse may need to assess an individual's capacity to agree to having their dressing changed.

If a decision is required for an examination, proposed treatment or hospital admission, then the healthcare professional who is proposing the examination, treatment or admission, must assess the individual's capacity to make the decision at the time that the decision needs to be made.

Some assessments can be carried out by multidisciplinary team members. For example, where an inpatient needs to access a different department for their treatment, multiple capacity assessments may need to be undertaken for each specific decision by each relevant department i.e. Radiology/Endoscopy. If an individual is found to lack capacity to make one decision regarding their treatment, this does not mean that they automatically lack capacity for all decision making.

If a healthcare professional does not feel confident in undertaking a capacity assessment, they can seek the support of a more experienced professional or consider escalation to the Trust's MCA Lead or the LPT Safeguarding Team. Factors such as those listed below may warrant escalation to the Trust 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.

7.3 **Mental Capacity assessment: The two-stage functional test**

To help determine if a person lacks capacity to make a specific decision, the Act sets out a two-stage test of capacity:

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

The Supreme Court support the below approach when completing an assessment to determine an individual's capacity to make a decision at the time the decision needs to be made (A Local Authority v JB [2021] UKSC 52). The two-stage test has been broken down into three questions as detailed below.

1: Is the person able to make the decision (with support if required)?

All practical and appropriate support to help the person make the decision themselves should be utilised e.g., Alternative methods of communication, or waiting for the effects of substances to wear off if appropriate.

2: If they cannot make the decision, is there an impairment or disturbance in the functioning of their 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.

3: Is the person's inability to make the decision because of the impairment or disturbance?

Codes of Practice & Case Law

CHAPTER 4 OF THE MCA CODE OF PRACTICE SETS OUT A TWO-STAGE TEST OF CAPACITY.

1. DOES PATIENT HAVE A DISTURBANCE OF THE MIND OR BRAIN OR IS THERE A DISTURBANCE AFFECTING THE WAY THEIR MIND OR BRAIN WORKS.

2. DOES THAT DISTURBANCE OR IMPAIRMENT MEAN THAT PATIENT IS UNABLE TO MAKE THE DECISION AT THE TIME IT NEEDS TO BE MADE.

THIS IS THE REVERSE OF WHAT IS STATED BY **S2 (1) MCA (2005). PC V CITY OF YORK COUNCIL (2013)** HIGHLIGHTS THIS AND INTRODUCES THE CAUSATIVE NEXUS BETWEEN THE DECISION AND THE INCAPACITY WHICH PROVIDES A MORE RIGOROUS ASSESSMENT.

7.4 A person is unable to decide if they cannot:

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

These factors are discussed in more detail below.

7.5 **Understanding information about the decision to be made**

To demonstrate 'understanding' a person needs to grasp 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 important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person to understand.

It is not necessary that the patient understands every element of what is being explained to them. In some cases, it may be enough to give a broad explanation using simple language. 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.

7.6 **Retaining information**

Case Law

PCT V LDV & B HEALTHCARE GROUP (2013) SETS OUT SOME BASIC INFORMATION REQUIRED TO BE UNDERSTOOD WHEN RECEIVING CARE OR TREATMENT;

- THE PURPOSE,
- NATURE AND
- CONSEQUENCES OF THE CARE/ TREATMENT.

AND

CC V KK & STCC (2012) DISCUSSES SALIENT POINTS "THE PERSON NEED ONLY COMPREHEND AND WEIGH THE SALIENT DETAILS RELEVANT TO THE DECISION AND NOT ALL THE PERIPHERAL DETAIL".

Information need only be held in the mind of the person long enough to make the specific decision at the time it is required.

7.7 **Using or weighing information as part of the decision-making process**

This requires the person to be able to engage in the decision-making process and to be able to see the various parts of the argument and relate them to each other. The person must be able to consider and weigh the arguments for and against a proposed action and understand the likely consequences before making a specific decision.

Case Law

WYE VALLEY V MR B (2015) AND WESTMINSTER CITY COUNCIL V MANUELA SYKES (2014) DISCUSS THE NEED FOR PATIENT TO BE PRESENTED TO AVAILABLE OPTIONS, THE NEED FOR PATIENTS WISHES, VALUES, BELIEFS AND FEELINGS TO BE CONSIDERED AND WHAT PATIENT WOULD DECIDE IF THEY HAD CAPACITY TO DO SO.

Case Law

CC V KK & STCC (2012) IS ALSO RELEVANT IN THIS PART "P MUST BE PRESENTED WITH DETAILED OPTIONS SO THAT THEIR CAPACITY TO WEIGH UP THOSE OPTIONS CAN BE FAIRLY ASSESSED".

7.8 **Communicating a Decision**

Any form of communication is acceptable. 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, in a coma, or had 'locked-in syndrome'.

7.9 **Concluding an Assessment of Capacity**

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.

7.10 **Recording of the Capacity Assessments**

It is good practice for professionals to carry out a proper assessment of a person's capacity to make a specific decision and to record the findings in the persons records. **Assessments may be evidenced by use of a template, within a SystmOne entry record.** Any record should be in appropriate detail, proportionate 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 evidence.

Case Law

RECORD KEEPING CASE LAW **SYNCLAIR V EAST LANCASHIRE HOSPITALS NHS TRUST (2015) AND AMDC V AG & ANOR [2020].**

8. Capacity Disputes

If, following a capacity assessment, there are still doubts over whether the individual has the capacity to make the specific decision at that time, or their decision has been challenged, then a second capacity assessment should be undertaken and completed by a different member of staff, if appropriate. It may sometimes be appropriate for multiple staff members to be involved in a capacity assessment. Details of who has undertaken all capacity assessments should be recorded in patient records.
Where uncertainties or significant disputes continue this should be escalated via your MCA leads. **Please also contact the LPT Safeguarding Team if the dispute is unresolved.**

9. Coercion and Undue Influence

9.1 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.

9.2 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 or call ☎ 0116 295 8977

9.3 Practitioners are also cautioned to be guided by Coercion and Control from within a domestic setting which may constitute Domestic Abuse, as described in the Domestic Abuse Act 2021.

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

10.1 The aim of an IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time the decision needs to be made, have no one else (other than paid staff) to support or represent them, or be consulted. IMCA's **must** be independent.

10.2 Under s35 MCA(2005) an IMCA **must** be instructed, and then consulted, for people, aged 16 and over, who have been assessed as lacking capacity for a specific decision and have no one else to support them (other than paid staff) in the following circumstances:

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.

10.3 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 to make a specific decision.
- 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 considered by a decision-maker as part of the process of their decision making and 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, an IMCA referral should be made with a follow up call regarding the urgency, but the care or treatment should not be delayed in urgent circumstances.

10.4 IMCAs must be given all reasonably practicable assistance to carry out their function. 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, Leicestershire and Rutland by Pohwer. To make an IMCA referral in Leicester, Leicestershire and Rutland contact:

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 the relevant 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.

10.5 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 for the specific decision.

10.6 When working out what is in the best interests of an individual, 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.

10.7 It is up to the decision-maker to ensure that they have sufficient information 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 and this must be considered as part of the decision making process.

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

10.9 When a family member is a primary carer for their relative, they still need to make best interest decisions under 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 a 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 concern. 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 (lpt.safeguardingduty@nhs.net).

10.10 If an individual is found to lack the capacity to make a decision regarding **serious medical treatment** at the time in which the decision needs to be made then an IMCA **must** be instructed if there are no other suitable persons to consult.

10.11 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.

10.12 If urgent treatment is required then this should not be delayed by instructing an IMCA, however the reason for the delay in contacting an IMCA should be fully recorded on the patients records on SystmOne. An IMCA should be instructed with minimal delay after the treatment has begun.

11. Consultation

11.1 The Act places a duty on the decision-maker to consult other people close to a person who lacks capacity to make a specific decision at the time in which the decision needs to be made.

Where it is practical and appropriate, the decision-maker has a duty to consult:

- Anyone who the person has previously named as someone that they want to be consulted.
- Anyone involved in caring for the person.
- Anyone interested in their welfare (for example family carers, close relatives, or an advocate).
- An appointed attorney under Lasting Power of Attorney.
- A deputy appointed by the Court of Protection.

Where a person has an attorney or deputy, they **must** make the decisions on any matters they have been appointed for. Attorneys and deputies should also be consulted, where practical and appropriate, on other matters affecting the person who lacks capacity to make a specific decision, as they may hold information on a person's beliefs, values, wishes and feelings which could aid the decision-maker.

If there is no-one available to consult, then the decision-maker should consider if an Independent Mental Capacity Advocate (IMCA) is required as outlined in section 9.

11.2 The aim of consultation is to find out:

- What the people consulted think is in the person's best interests in this matter, and
- If they can give information on the person's wishes and feelings, beliefs and values.

Decision-makers must be able to demonstrate that they have taken all appropriate views into account, and they must be able to explain why they have or have not consulted a particular person. Consultations and decisions made not to consult a person should be clearly recorded in the individual's record when documenting the decision-making process.

11.3 Those who are consulted may not 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 conflicting views. All those consulted must be made aware of the pros and cons of all available options during consultation.

Consultation can be via direct discussion, via telephone, or if appropriate can be via a meeting for complex decisions or where there are lots of people to consult.

11.4 Where it is not possible to hold consultations because, for example, urgent treatment is necessary, staff must still act in the patient's best interests.

12. Confidentiality

12.1 There may be occasions where it is in an individual's best interests for personal information (such as a medical condition) to be shared with family and friends or others who need to be consulted (as set out in section 9). Decision-makers must balance their duty to consult others with the right to confidentiality of the individual. Decision-makers should only share information with people who it is appropriate to consult and should only share information that is relevant to the specific decision that is required.

12.2 Where an attorney under a Health and Welfare Lasting Power of Attorney (LPA) has been appointed, they will be entitled to access 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.

13. MCA and Safeguarding

13.1 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.

13.2 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.

13.3 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 adult's referral should be made.

14. Children and Young People Aged 16 to 17 Years

14.1 Most of the MCA applies to those aged 16-17 who may lack capacity to make specific decisions at the time the decision needs to be made but there are three exceptions:

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

14.2 The MCA should be considered alongside the Children's Act 1989. 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. There are currently no specific rules for deciding when to use either the Children Act 1989 or the MCA, or when to apply to the High Court. If LPT staff are unsure how best to support a young person aged 16-17

then advice should be sought from the LPT Safeguarding Team at lpt.safeguardingduty@nhs.net.

14.3 Generally, a person with parental responsibility for a young person can consent to the young person receiving care or medical treatment where they lack capacity to make the specific decision for themselves at the time in which it needs to be made. However, healthcare professionals can carry out treatment or care for a young person who has been assessed as lacking capacity to make the specific decision if it is in their best interests without the consent of a person with parental responsibility. Healthcare professionals must act in the best interests of the young person, as they would for an adult, and must consult everyone who it is practical and appropriate to consult as outlined in section 10. This would include those with parental responsibility. Regard should also be given to the young person's right to confidentiality, and only appropriate and relevant information should be shared and there may be times when it is not appropriate to consult with parents (for example if the young person does not want their parents involved, or where there have been concerns regarding abuse).

14.4 Please use the Decision-Making Tool to document any assessments of decision making for those under sixteen (see Appendix 6).

14.5 The MCA generally does not apply to those under the age of 16 except in the following circumstances:

- The Court of Protection can make decisions about a child's property or finances if the child lacks capacity to make such decisions and is unlikely to be able to make financial decisions when they reach the age of 18 under section 18(3).
- Offences regarding the ill-treatment or wilful neglect of a person who lacks capacity can apply to victims under the age of 16 under section 44.

15. Lasting Power of Attorney

15.1 The MCA allows a person to appoint a Lasting Power of Attorney (LPA) to act on their behalf if they should lose capacity in the future. A power of attorney is a legal document which allows the appointed person – the Attorney (also known as a Donee) - the authority to make specified decisions on behalf of a person who lacks capacity (the Donor). The LPA is appointed at a time where the Donor has the capacity to make the decision to appoint the Attorney for a time where the Donor may lack capacity. There can be more than one Attorney. If there is more than 1 Donee, then it will state whether they must make the decision jointly or jointly and severally on the Donors behalf. All LPA's must be registered with the Office of the Public Guardian (OPG) before use. The MCA replaced the old Enduring Powers of Attorney Act 1985 however existing Enduring Powers of Attorney are still valid.

15.2 Property and Financial LPAs cover property and financial affairs, and Health and Welfare LPAs cover personal welfare (including decisions on medical treatment where the LPA is the decision maker) for people who lack the

capacity to make decisions for themselves at the time in which the decision needs to be made.

15.3 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/government/organisations/office-of-the-public-guardian .

Attorneys are in a position of trust and 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: lpt.safeguardingduty@nhs.net

If necessary, concerns can be raised via the Office of the Public Guardian Safeguarding Office who may refer to the Court of Protection to have the LPA revoked.

16. Court of Protection

16.1 The Court of Protection is the ultimate arbiter for all matters relating to capacity. It has all the same rights, privileges and authority as the High Court. 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.

16.2 For cases about serious or major decisions concerning medical treatment the NHS Trust (please email lpt.safeguardingduty@nhs.uk) or other organisation responsible for the patient's care will usually make the application. If the local authority are concerned about a decision that affects the welfare of a person who lacks capacity, they should make the application.

16.3 In certain situations where an individual lacks capacity and does not have a Lasting Power of Attorney (LPA) the Court of Protection may appoint a **Court Appointed Deputy** who then takes on the same functions as an Attorney either for a specified period or indefinitely. Multiple Deputy's may be appointed in certain circumstances.

17. Advance Decisions

17.1 There is no prescribed form for an advance decision unless it deals with life-sustaining treatment.

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 capacity, then a capacity assessment should be completed at the time in which the advance decision is being made to determine if the individual has the capacity to make the advance decision at that time.

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

17.3 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 3) if the patient lacks capacity.

18. Advance Decision to Refuse Treatment (ADRT) see Appendix 4

18.1 People have the right to consent to or refuse treatment and people can say in advance that they want to refuse treatment if they lose capacity in the future. An ADRT must state what specific treatment is refused. An ADRT can be cancelled 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 treatment or care.**

18.2 If the ADRT is regarding life-sustaining treatment then it must:

i. be in writing (it can be written by someone else or recorded in SystmOne
ii. be signed and witnessed, and
iii. state clearly that the decision applies even if life is at risk.

18.3 There is no prescribed format for other Advance Decisions and they can be written or verbal (unless they relate to life-sustaining treatment – see 18.2). But an ADRT:

i. Must state precisely what treatment is to be refused – a statement giving a general desire is not enough,
ii. May set out circumstances when the refusal should apply – it is helpful to include as much detail as possible,
iii. Will only apply at a time when the person lacks capacity to consent to or refuse specific treatment.

18.4 When creating written ADRT's the following format is recommended:

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 hand 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.

When taking verbal ADRTS's the following should be recorded in the MCA template on the person's SystmOne records:

1. A note that the decision should apply if the person lacks capacity to make treatment decisions in the future,
2. A clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply,
3. Details of someone who was present when the oral advance decision was recorded and the role in which they were present (for example, healthcare professional or family member), and
4. Whether they heard the decision, took part in it or are just aware that it exists.

18.5 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.

18.6 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.

18.7 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.

18.8 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.

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

19.1 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 Decision to refuse a specific treatment for a mental disorder is in place then 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.

19.2 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.

19.3 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.

20. Advanced Decisions to Refuse Treatment

20.1 Clinical staff can find themselves in crisis situations where an adult maybe refusing life sustaining treatment. In such situations staff must check if a valid ADRT is in place for the specific treatment in line with the criteria in section 18.2.

20.2 In crisis situations where there is a doubt regarding an adult's capacity to make the decision to consent to life saving treatment, staff should carry out a capacity assessment to make the decision to proceed with the required life sustaining treatment. Further information on capacity assessments can be found in section 7.

20.3 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 2003,* 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".

21. Suicide, Murder and Manslaughter

21.1 Nobody can request procedures that are against the law, such as help with supporting 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 complete suicide.

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

22.1 An Advance Decision to refuse Electro-Convulsive Therapy (ECT) can be overridden if the patient 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' condition (see section 58A(5) and 62 (1A) of the Mental Health Act 1983). Clinicians are advised that going against an Advance Decision may leave them open to challenge so documentation of the justification for overriding must be clear.

23. Staff Roles and Responsibilities Regarding Advanced Decisions

23.1 LPT staff should be able to explain to an adult with capacity what an Advance Decision is and the legal implications.

23.2 Staff should be aware if a patient that they propose to treat has made a previous Advance Decision. Before the advance decision can be applied there must be proof that the advance decision:

- Exists
- Is valid, and
- Is applicable in the current circumstances.

23.3 Valid Advance Decisions have the same validity for people who lack capacity to make the decision as people with capacity to make the decision.

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 suggesting they have changed their mind,
- Withdrawn their decision,
- Has appointed an LPA after the Advance Decision was made and the LPA was given authority to make decisions on the relevant treatment covered in the advance decision or
- Would have changed their decision if they had known more about the current circumstances (for example they are now pregnant or there are new medications or treatments which were not in existence when the advance decision was made).

23.4 If it is established that an Advance Decision does not exist, is not valid and/or applicable then it may still be an expression of the person's wishes during the decision making process in the persons best interests.

23.5 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.

23.6 If LPT staff have genuine doubts about the existence, validity or applicability of an Advance Decision treatment, it 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: lpt.safeguardingduty@nhs.net

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

24.1 The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency if 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 Cardio-Pulmonary Resuscitation (CPR) should be attempted if the person's heart and breathing stop.

24.2 Advance Care Plans are a more comprehensive, holistic plan. ReSPECT should not replace these but should 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.

24.3 ReSPECT advise and conversations should follow the ReSPECT principles:

- 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 for more information.

25. Advance Statements – see Appendix 4

25.1 An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding.

An Advance Statement is a written statement about what a patient would like to happen if they should lose capacity in the future and can contain information such as:

- What treatments they would prefer
- Who they would like to be contacted in a crisis.
- Any spiritual or religious views and requests
- Food preferences.

25.2 To make an advance decision a person must be over 18 years and have the mental capacity to make the advance statement at the time the statement is made.

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

26. Advanced Care Plans

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

26.2 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).

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

27. Joint Crisis Planning

27.1 Practitioners and individuals may wish to consider the use of advance care planning in the event of a crisis, 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.

28. Restraint and Restriction - DoLS

28.1 The MCA makes provision for the restraint of an individual providing certain criteria are satisfied. Restraint is when someone uses force (or threatens to) to make someone do something they are resisting, and when someone's freedom of movement is restricted, whether or not they are resisting.

Restraint can be appropriate when used from time to time to prevent serious harm to a person who lacks capacity – if

- it is a proportionate response to the likelihood and seriousness of the harm, and
- all other less restrictive means of achieving this have been tried.

28.2 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.

28.3 To be lawful under the Mental Capacity 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, unless others are at risk of harm whereby there is a legitimate reason to physically intervene.

Records will need to show:

- The assessment and decision-making process.
- The less restrictive alternatives that were considered, and why they were rejected.

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

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

28.6 If any restraint is required a care plan and risk assessment must be completed in line with the defined LPT standards.

28.7 When using restraint as part of their duties clinical staff are protected from liability if they reasonably believe it is <u>necessary</u> 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. It is also acceptable to physically intervene if others are at risk of harm whereby there is a legitimate reason to act.

28.8 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.

28.9 The use of blanket restrictions should be avoided, and care plans should be person-centred and personalised to the individual.

28.10 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: lpt.safeguardingduty@nhs.net.

28.11 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: lpt.safeguardingduty@nhs.net

28.12 If restraint is used frequently and other decisions have been made that significantly restrict a person's liberty, it should be considered whether the person's liberty is being deprived. If so, authorisation under the Deprivation of Liberty Safeguards (DoLS) must be requested, or changes must be made to the care of the person to reduce the restrictions of liberty. This authorisation can only be approved by ward staff completing the DoLS application and sending it to the Local Authority with a copy to the LPT Safeguarding Admin team lpt.adult-safeguarding@nhs.net.

29. Interface between the Care Act (2014) and the MCA – see Appendix 5

29.1 The MCA and The Care Act (2014) work together to promote the safety and wellbeing of adults with care and support needs. The Care Act 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 (including self-neglect). In all safeguarding activity, due regard must be given to the Mental Capacity Act. Safeguarding duties also apply to adults who lack the capacity to maintain their safety and well-being.

29.2 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.

29.3 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 include:

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

29.4 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 regarding risks may resolve the situation. If resolution cannot be found then 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 https://www.llradultsafeguarding.co.uk/wp-content/uploads/2015/03/LLR-Safeguarding-Adults-Thresholds-Guidance-2.pdf).
At any stage in the process staff can contact the LPT Safeguarding Team for advice on lpt.safeguardingduty@nhs.net/.

29.5 The MCA introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks 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. Further advice and support can be gained from the LPT Safeguarding Team on lpt.safeguardingduty@nhs.net.

Case Law

DOLS OFFER A LEGAL FRAMEWORK TO PROTECT PEOPLE WHO MAY BE DEPRIVED OF THEIR LIBERTY IN A HOSPITAL OR CARE HOME, FOR THE PURPOSES OF CARE OR TREATMENT AND ARE UNABLE TO GIVE CAPACITOUS CONSENT TO THIS. DOLS CANNOT BE USED TO SAFEGUARD PATIENT FROM ABUSE.

SCHEDULE A1 (12- 20) MCA (2005) OUTLINES THE QUALIFYING REQUIREMENTS FOR DOLS. THE SUPERVISORY BODY MUST ARRANGE FOR THESE REQUIREMENTS TO BE ASSESSED TO ESTABLISH WHETHER A DOLS AUTHORISATION IS REQUIRED.

SCHEDULE A1 (33- 48) MCA (2005) OUTLINES THE ASSESSMENTS REQUIRED TO AUTHORISE A DOLS. IF PATIENT DOES NOT MEET ANY ONE OF THE SIX ASSESSMENTS OUTLINED IN SCHEDULE A1 MCA (2005) THEN THE PROCESS MUST STOP AND A DOLS CANNOT BE AUTHORISED.

TO IDENTIFY WHETHER PATIENT MAY BE BEING DEPRIVED OF THEIR LIBERTY USE THE SUBJECTIVE, OBJECTIVE, AND IMPUTABLE TO THE STATE ELEMENTS OF **STORK V GERMAN (2005)** IN CONJUNCTION WITH THE **CHESHIRE WEST (2014) ACID TEST** RULING OF 'CONTINUOUS SUPERVISION AND CONTROL AND FREE TO LEAVE', AND THE CONCRETE SITUATION FRAMEWORK OFFERED BY **GUZZARDI V ITALY (1980)**

ADDAS FORM 1 IS THE STANDARD REQUEST AND URGENT AUTHORISATION FOR A DEPRIVATION OF LIBERTY. THIS SHOULD BE COMPLETED IN ADVANCE BEFORE THE NEED FOR DEPRIVATION OF LIBERTY BEGINS. IT SHOULD BE COMPLETED BY THE CARE HOME MANAGER OR SENIOR HOSPITAL STAFF AND SENT TO THE LOCAL AUTHORITY WHERE PATIENT USUALLY RESIDES. URGENT AUTHORISATIONS SHOULD ONLY BE COMPLETED IN EXCEPTIONAL CIRCUMSTANCES.

29.6 Speaking up, raising concerns and whistleblowing are essentially all the same activity. There is a national preference however, to use the words speaking up as it is a broad term and can be expressed as including anything that gets in the way of the delivery of great care. It encourages issues to be raised at an early stage before they may even be considered 'a concern'. Speaking up can also be seen as a positive term – people can speak up about what is going well or what could go even better, not just about things that 'concern' them.

30 MCA and DoLS Support

30.1 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

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

30.3 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 and Public Protection Policy
- Mental Health Act Policies

The above list is not intended to be exhaustive.

31. Monitoring Compliance and Effectiveness

31.1 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. 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
A Local Authority V JB (by his litigation Friend, the official Solicitor)

LPT Policy and Procedures – copies can be found on the Trust Website on the policies page.
Consent to Treatment
Covert Medication Policy
Medication Management

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

Person has capacity to make the decision.

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

NO

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

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.

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 retain 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

<table>
<tr><th colspan="2">Best Interests Assessment Form</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Name</td><td></td></tr>
<tr><td>Date of Birth</td><td></td></tr>
<tr><td>NHS Number</td><td></td></tr>
<tr><td>Name of assessor</td><td></td></tr>
<tr><td>Job Title</td><td></td></tr>
<tr><td colspan="2">Best Interests decision required</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Is there a valid Lasting Power of Attorney? (you must see written proof).</td></tr>
<tr><td>Yes:</td><td>Consult with the LPA and ensure that the LPA decision is clearly recorded in the records.</td></tr>
<tr><td>No</td><td>Continue with the checklist</td></tr>
<tr><td colspan="2">Is there a Court Appointed Deputy or Court of Protection order with authority over the decision?</td></tr>
<tr><td>Yes</td><td>Clarify details and seek advice from manager or LPT Safeguarding Team</td></tr>
<tr><td>No:</td><td>Continue with the checklist.</td></tr>
<tr><td colspan="2">To make a best interest decision for another person you must consider the following Best Interest Checklist as defined below.</td></tr>
<tr><td colspan="2">The relevant information: consider all the relevant circumstances (clinical opinion, history, assessed needs, risks, social factors, emotional factors, available options, etc.)</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td colspan="2"></td></tr>
</table>

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	

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.

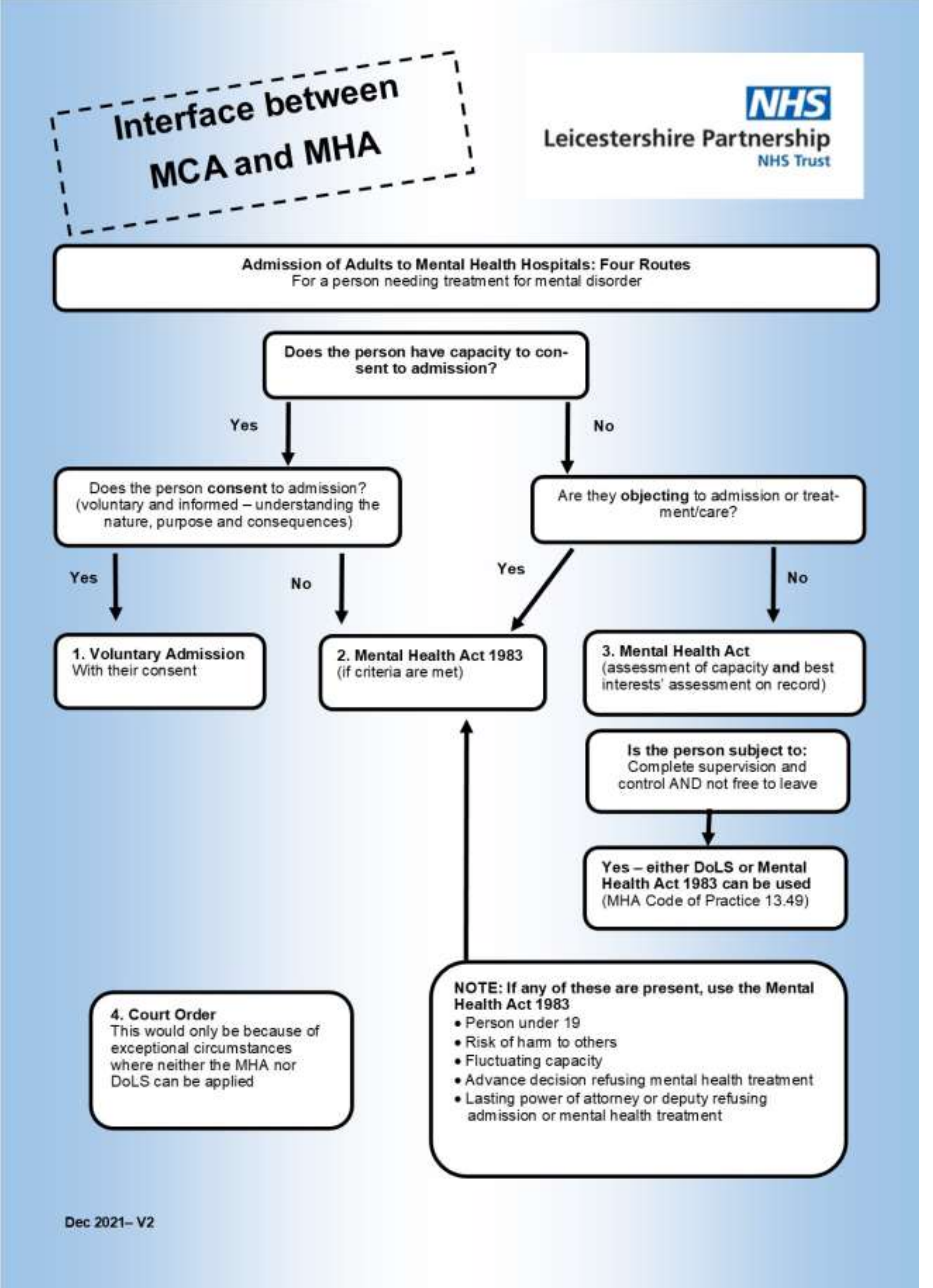
I present this document in the understanding that it will be followed where possible, and in the event that the choices expressed in this document are not followed, I will be provided with a full explanation when I regain capacity.

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.

<table>
<tr><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td>High risk: Complete a full EIA starting click here to proceed to Part B</td><td></td><td>Low risk: Go to Section 4.</td><td>X</td></tr>
<tr><td colspan="4">Section 4</td></tr>
<tr><td colspan="4">If this proposal is low risk please give evidence or justification for how you reached this decision:</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td>Signed by reviewer/assessor</td><td></td><td>Date</td><td>19th May 2021</td></tr>
<tr><td colspan="4">Sign off that this proposal is low risk and does not require a full Equality Analysis</td></tr>
<tr><td>Head of Service Signed</td><td></td><td>Date</td><td>19th May 2021</td></tr>
</table>

Appendix 8

PRIVACY IMPACT ASSESSMENT SCREENING

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.

Name of Document:	Mental Capacity Act Policy		
Completed by:	Neil King		
Job title:	Head of Safeguarding & Public Protection	**Date**	March 2024

	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

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.

Data Privacy approval name:	
Date of approval:	

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

Appendix 9

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	☑