Humber Teaching
NHS Foundation Trust

Mental Capacity Act 2005 and Best Interests Decision Making Policy (M-001)

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1. INTRODUCTION

The Mental Capacity Act ((MCA) 2005 provides a legal framework for acting and making decisions on behalf of vulnerable people who lack the mental capacity to make specific decisions for themselves. This is a statutory framework to empower and protect individuals aged 16 and over.

It aims to ensure that any decision made, or action taken on behalf of an individual who lacks the capacity to make that decision them self, will always be made in their best interest. The MCA 2005 lists five 'statutory principles' (Listed under section 8) which are the values that underpin the legal requirements and assessment of capacity for all decisions and best interests' framework.

Further provisions introduced in 2009, The Deprivation of Liberty Safeguards (DoLS), continues to be the legal framework to protect the rights of vulnerable individuals who, for their own safety, need to be accommodated under a care and treatment regime that could deprive them of their liberty.

The new Mental Capacity (Amendment) Act 2019 received Royal Assent in May 2019 and was expected to come into force on 1st October 2020. The implementation date has now been delayed and a new target date for implementation not announced at this point. The Act creates the new scheme, the Liberty Protection Safeguards (LPS) that will replace the current DoLS arrangements.

This policy should be read in conjunction with the Safeguarding Adults Policy and Procedures (N-024) and Safeguarding Children Policy and Procedures (N-045). Those who lack capacity are amongst the most at risk of abuse and/or neglect. Mental capacity should be considered in cases where abuse is suspected or proven. An individual who wilfully neglects or ill-treats a person who lacks capacity can be prosecuted under section 44 of the Act which carries a custodial sentence.

1.1. Key Principles of the Mental Capacity Act

The Act is underpinned by a set of five statutory principles which should be considered whenever someone is planning to make a decision under the Act. They are:

- A person must be assumed to have capacity unless it is established, they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- 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
- 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 persons rights and freedom of action

2. SCOPE

Everyone working with, or caring for, an individual aged 16 or over, who may lack the capacity to make a decision or agree to an action at the specific time that it needs to be made. Doing so ensures that decisions and actions follow's a process prescribed in law, within a recognised framework to ensure they are not in breach the European Convention on Human Rights (ECHR).

3. POLICY STATEMENT

The purpose of this Policy is to provide staff working in or with Humber Teaching NHS Foundation Trust with guidance about the MCA 2005. It sets out the main provisions and the duties placed on health and social care professionals.

This Policy supplements and should be used in conjunction with the MCA 2005. The Trust is committed to ensuring that all individuals who are using our services are treated with dignity and respect, and also including their families/carers receive appropriate care and support.

This Policy is not a replacement for the Mental Capacity Act Code of Practice (2007) and the Deprivation of Liberty Safeguards Code of Practice (2008) addendum.

All Staff must work within the scope of this Policy and be compliant with the MCA 2005 at all times when working with people using services within the Trust also including the procedures laid out within the associated MCA 2005 Code of Practice.

4. DUTIES AND RESPONSIBILITIES

4.1. Chief Executive and Executive Directors

Overall responsibility for ensuring the Trust is compliant with the Act and its principles.

4.2. Named Professional for Adult Safeguarding and MCA Lead

Responsible for providing support and advice to clinicians where capacity issues may be particularly complex, and for ensuring there are quality and governance structures in place with regards to compliance. The MCA Lead is also responsible for the provision of training.

4.3. Divisional Leads

Responsible for ensuring the implementation of this policy within their areas and ensuring staff are compliant with the MCA 2005.

4.4. Service Managers, Modern Matrons and Team Leaders

To understand the importance of, and apply the MCA 2005, to ensure people who use services receive care that is safe and within the legal frameworks.

To ensure that professionals use the Trust approved documentation when documenting an Assessment of Capacity and Best Interest Decision.

To identify any individual training needs and ensure all attend mandatory training.

4.5. MCA Lead, Safeguarding Team, Mental Health Legislation Team and Legal Services Team

To provide advice and strategic oversight in relation to the application and compliance of the MCA 2005 and Deprivation of Liberty safeguards.

4.6. All staff

To act within the provisions of the Act, understand their responsibilities and duties under it and maintain compliance with Mental Capacity Act training as advised by the National Mental Capacity Act Competency Framework.
Mental Capacity Act Training Framework 2018 (Bournemouth University)

5. DEFINITIONS

5.1. Mental Capacity

This broadly refers to the ability of an individual to make a decision about specific elements of their life. It is also sometimes referred to as “competence”. It is not an absolute concept – different degrees of capacity are needed for different decisions, and the level of competence required rises with the complexity of the decision to be made. Neither does it matter whether the condition is temporary or permanent but in the case of a temporary condition, the judgement would have to be made as to whether the decision could be delayed until capacity returned. It is clear from both the MCA 2005 and the Code of Practice that this refers specifically to a person’s capacity to make a

particular decision at the time it needs to be made. Someone can lack capacity to make some decisions but not others.

5.2. Consent
This is the voluntary and continuing permission of the person to the intervention or decision in question. It is based on an adequate knowledge and understanding of the purpose, nature, likely effects and risks of that intervention or decision, including the likelihood of success of that intervention and any alternatives to it. Permission given under any unfair or undue pressure is not consent. A person who lacks capacity to consent is unable to consent or refuse treatment.

See the Trusts Consent to Assessment, Examination and Treatment Policy and Procedure (N-052) for further information.

5.3. Best Interests
This is a core principle that underpins the MCA 2005. It stresses that any act done or decision made on behalf of an individual who lacks capacity, must be done or made in their best interests. This principle covers all aspects of financial, personal welfare, health care decision-making and actions.

5.4. Decision-maker under the Act
Many people may be required to make decisions or act on the behalf of someone who lacks capacity to make decisions for them. The person making the decision is referred to as the decision-maker and it is the decision-maker's responsibility to work out what would be in the best interest of the person who lacks capacity. The decision maker must be the person carrying out the act/treatment.

5.5. Restraint
The use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement whether they resist or not (MCA Code of Practice).

5.6. Lasting Power of Attorney (LPA) under the Act
This makes provision for an individual with capacity aged 18 or over to appoint an attorney (or attorneys) to make decisions about the welfare once they lose capacity. This can cover personal welfare decisions (including decisions about health care) and/or decisions relating to their property or affairs. An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. A 'donor' is the person who makes an LPA while they still have capacity.

5.7. Court of Protection
This is a specialist court which deals with complex issues relating to people who lack capacity to make specific decisions.

5.8. Independent Mental Capacity Advocate (IMCA)
A person who can represent and support an individual who lacks capacity in situations where the person has no one else to support them.

5.9. Court Appointed Deputy
Someone who has been appointed by the Court of Protection to make decisions on behalf of an individual who lacks capacity.

5.10. Office of the Public Guardian (OPG)
In addition to keeping a register of deputies, LPA and Enduring Powers of Attorney, it also has the responsibility of monitoring deputies and attorneys' and investigates any complaints about attorneys or deputies.

6. PEOPLE COVERED BY THE MENTAL CAPACITY ACT

This applies to people aged 16 or over who lack capacity to make their own decisions. Having mental capacity means that a person is able to make their own decisions. Capacity can vary over time and by the decision to be made. A lack of capacity could be the result of a permanent, temporary or fluctuating condition.

The MCA 2005 is specifically designed to cover situations where someone is unable to make a decision because their mind or brain is affected, for instance, by illness or disability, or the effects of drugs or alcohol. A lack of mental capacity could be due to:

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Physical or mental conditions leading to confusion, drowsiness or loss of consciousness including Delirium, Concussion, and the long-term effects of brain damage
- The symptoms of alcohol or drug use

However, it is important to know that having a particular diagnosis or disability should not of itself be taken as an indication that the person does or does not lack capacity. All individuals must be presumed to have capacity, unless it is established otherwise under the capacity test set out in the MCA 2005.

6.1. Younger People

The MCA 2005 applies to people of 16 or over who lack capacity to make their own decisions. Most of the provisions apply to young people of 16 and 17 years old. Decisions relating to treatment of young people of 16 and 17 who lack capacity must be made in their best interests in accordance with the principles of the MCA 2005. The young person's family and friends should be consulted where practicable and appropriate. However, a person needs to be 18 or over to make an advance decision, a Lasting Power of Attorney (LPA) or a will.

The Children Act 1989, 2004 covers the care and welfare of children in most situations. The MCA 2005 applies to children under 16 years in two ways:

- The Court of Protection can make decisions about the property and affairs of a child where it is likely that the child will lack capacity to make those decisions when they reach 16 years old
- The criminal offence of ill treatment or neglect applies in relation to acts or omissions toward children who lack capacity

Parents/those with Parental Responsibility are not able to give consent to care arrangements on behalf of a 16/17 year old that would amount to a deprivation of liberty as highlighted in Re D Judgement **[2019] UKSC 42.** *On appeal from: [2017] EWCA Civ 1695.* This significant ruling – (In the matter of D (A Child) (supremecourt.uk)) - by the Court of Appeal concerns the extent to which parents are able to consent to the confinement of their incapacitated children in light of *Cheshire West*.

The Trusts 'Consent policy' (N-052) explores this area in more detail.

7. MENTAL HEALTH ACT 1983, 2007

If a person is detained under the Mental Health Act (MHA) 1983, 2007, the MCA 2005 does not apply to treatment for the person's suffering with a mental disorder, which can in some circumstances be given without consent under the MHA 1983, 2007 itself. Therefore, advance

decisions and Lasting Powers of Attorney are not binding, and deputies cannot consent or refuse treatment for mental disorder given under the MHA 1983, 2007. These should none the less be taken into account when making treatment choices under the MHA 1983, 2007. However, the MCA 2005 does apply to treatment for a condition or illness other than mental disorder for an individual detained under the MHA 1983, 2007.

An individual's capacity to make decisions about their care and treatment and arrangements for providing that care and treatment, should be assessed in psychiatric as well as general hospitals, regardless of whether or not the person is detained under the MHA 1983. The principles of the MCA 2005 apply to all individuals and should be seen as good practice; capacity and limits placed on freedom of movement should be documented in care plans; to enhance access to relevant safeguards. Consideration should be given to the use of the IMCA, in relation to decisions under the MCA 2005.

8. PROCEDURES

8.1. How does the MCA Define Lack of Capacity?

A person lacks capacity in relation to a matter if, at the time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Under the MCA 2005, a decision about one person's capacity can be made by anyone who follows the assessing criteria.

For more complex decisions, relating to care or treatment, it may be appropriate that the decision may be taken by a health or social care professional.

Professional involvement might be needed if:

The decision that needs to be made is complex or has serious consequences

- An assessor concludes that a person lacks capacity, but the person wishes to challenge that decision
- Family, carers and/or professionals disagree about a person's capacity
- There is conflict of interest between the assessor and the person being assessed
- The person being assessed is expressing different views to different people;
- Somebody might challenge the person's capacity to make the decision, either at that time or later
- A vulnerable person may have been abused but lacks the capacity to make decisions that protect them
- A person repeatedly makes decisions that could put them at risk or could result in suffering or damage

The MCA 2005 sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" test. No one can be regarded as lacking capacity to make decisions in general. The MCA 2005 makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead to unjustified assumptions about their capacity.

8.2. When do I test capacity?

The starting point must always be to assume that a person has the capacity to make a specific decision. Some people may need help to be able to make or communicate a decision, but this does not necessarily mean that they lack capacity to do so.

Should there be reason to doubt a person's capacity an assessment **must** be carried out. Reasons that people may doubt a person's capacity include:

- The persons behaviour or circumstances cause doubt
- Somebody else says they are concerned about the persons capacity, or
- The person 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

When an **urgent** decision needs to be made it is possible to treat a person if it is reasonably believed that they lack capacity to consent to the treatment and that the treatment is in their best interests and necessary to save their life or prevent a significant deterioration in their condition. The decision must be documented using the approved assessment and best interest templates immediately after the delivery of the care and treatment. It is important to keep the person as informed as possible throughout this process, as appropriate.

Where a patient who is subject to a DoLS in the community is admitted informally to a mental health inpatient unit, a capacity assessment should be carried out and documented accordingly to evidence decision making around the informal admission.

8.3. How do I Test Capacity?

It is important that if capacity is doubted, it needs to be tested by asking the following questions and recording detailed answers with reasons:

- Stage 1 – does the person have impairment or, a disturbance in the functioning of their mind or brain? (If 'No', the person cannot be assessed as lacking capacity. If 'Yes', proceed to stage two)
- Stage 2 – does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

Capacity relates to specific matters and can change over time; it should therefore be reassessed as appropriate in respect of specific treatment decisions.

All assessments of capacity should be recorded on the Trust approved assessment of capacity forms (these can be electronic or paper copies). Detailed rationale must be given for every element.

A person is unable to make a decision if they cannot:

Understand information about the decision
A person is not to be regarded as being unable to make a decision if s/he is able to understand through the use of appropriate means for example; using simple language, visual aids etc.

Retain the information
The fact that the person is only able to retain the information for a short period of time does not prevent him/her from being able to make a decision

Use or weigh that information
It is not enough to just understand and retain the information the person needs to be able to consider the consequences of carrying out or not carrying out the decision.

Communicate their decision
By talking, use of sign language or other means. All attempts should be made to enable a person to communicate their decision, this may include, visual aids, non-verbal gestures etc. A complete inability to communicate is rare, however, in these circumstances the Act is clear that a person should be treated as if they are unable to make a decision.

An answer NO to any one of the above will constitute a lack of capacity to make that particular decision.

- Any assessment of capacity should be clearly and contemporaneously recorded using the Trusts mental capacity paperwork on the patient's electronic patient record - Mental Capacity Assessment Form. When recording the outcome of the test the assessor must also record:

    - The specific decision being assessed
    - The support given to the person to make the decision themselves
    - How the diagnostic test was assessed and any relevant evidence
    - How the functional test was undertaken and how the assessor reached their conclusion (not simply Yes or No answers)
    - That the person is unable to make a decision **because** of the impairment of, or disturbance in the functioning of the mind or brain

A flowchart in the booklet for staff (Introduction to MCA and DoLS) gives an overview of the process to follow when a person's capacity is in question.

Some of the key principles to bear in mind when assessing capacity are as follows:

A person's capacity must be assessed specifically in relation to their capacity to make a particular decision at the time it needs to be made.

A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour.

It is important to take all possible steps to try to help people make a decision for themselves, e.g. would the person have a better understanding if information was explained or presented in another way? Are there times of day when the person's understanding is better? Are there locations where they may feel more at ease? Can anyone help the person to express a view or make a choice? e.g. a family member or carer or someone to help with communication?

8.4. What is a Best Interest Decision?

Once it has been established that a person lacks the capacity to make a particular decision, any decisions made on the persons behalf must be made in their best interests. In determining this, regard must be had to all relevant factors such as whether the person may regain capacity in the future, ascertaining past and present wishes and feelings of the person and their beliefs, values and other factors, and the views of others important to the person.

Where present and valid, advance decisions to refuse treatment, and advance care planning should be adhered to, and Lasting Power of Attorney must be consulted within the decision making process.

8.5 Who can make a Best Interest Decision?

The MCA 2005 identifies these people as a 'Decision Maker 'a person who makes a decision on behalf of a person who lacks the capacity to consent'. They are people who are legally responsible to work out what would be in the best interests of the person. Different people can be decision makers at different times dependent upon the decision to be made.

If the decision to be made is to carry out surgery, the decision maker will be the person responsible for carrying out the surgery, which would be the surgeon. Another example would be the decision maker in relation to treatment would be the doctor but if the decision was in relation to residence this would probably be the social worker.

For everyday acts of treatment or nursing care there is no requirement to formally set out how a best interest decision has been made as this would form part of the persons care plan, however decisions about more complex or contentious decisions should be made in a Best Interests Meeting and documented formally by the decision maker.

Excluded Decisions

Section 27 MCA 2005 lists certain decisions that can never be made on behalf of a person who lacks capacity.

These include:

- Consenting to marriage or civil partnership
- Consenting to sexual relations
- Consenting to a divorce decree being granted on the basis of two years separation
- Consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation
- Consenting for a child to be put up for adoption by an adoption agency
- Consenting to the making of an adoption order
- Discharging parental responsibilities in matters not relating to a child's property
- Giving consent under the Human Fertilisation and Embryology Act 1997

Mental Health Act – Nothing in the Act Authorises Anyone:
To consent to a patient being given medical treatment for a mental disorder if, at the time when it is proposed to treat the patient, the treatment is regulated by part 4 of the Mental Health Act 1983.

The MCA 2005 has created statutory rules with clear safeguards so that individuals can make decisions in advance to refuse treatment if they should ever lack capacity. The decision must be made by a person who is 18 years or over at the time when the person has capacity to make it and it must specify the treatment to be refused. This advance decision may be withdrawn by the person at any time by any means and is not valid if at the material time the person who made it still has capacity to give or effuse consent to the treatment being proposed.

If there is any doubt as to the validity or applicability of the advance decision then it should be referred to the Court of Protection for the Court to decide (this policy should be read in conjunction with Trust Guidance on Advance Statements / Decisions).

8.6 What is a Best Interest Meeting and what do I need to consider when carrying out a Best Interest Meeting?

This is a forum initiated at the request of the decision maker when a decision or action needs to be taken and the person lacks the capacity to consent.

The decision maker will invite a group of people (relevant to the decision to be made) to consider what is in the persons best interests. This must include family or friends. If the person does not have any family or friends, then an IMCA (Independent Mental Capacity Advocate) must be instructed. This does not always have to be a face to face meeting as long as the decision maker follows the guidance and consults with all relevant others (see Best Interests Pathway). Any best interest decision should be clearly documented, including detailed information about who made the decision and why the decision was considered to be in the person's best interests.

Decision makers should always:

Encourage participation by the person in the decision making process; make any reasonable adjustments to enable the person to take part in making the decision.

Identify all the relevant circumstances; this would be 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 persons views; this would mean trying to find out the person's past and present wishes and feelings; these could have been expressed verbally or in writing – which would be known as an advance decision, or through behaviour or habits.

Acknowledge any beliefs and values; religious, cultural, moral that would influence the decision in question.

Avoid discrimination; do not make assumptions based upon a person's age, appearance, condition or behaviour.

Consider if the person is likely to regain capacity; if so, can the decision wait?

Consult others; relevant to the decision to be made, for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.

In particular, try to consult:

- Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues.
- Anyone engaged in caring for the person.
- Close relatives, friends or others who take an interest in the person's welfare.
- Any Attorney appointed under a Lasting Power of Attorney made by the person.
- Any Deputy appointed by the Courts of Protection to make decisions for the person.
- For decisions about serious medical treatment where there is no one to consult who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.
- Avoid restricting the person's rights; review other care or treatment options that maybe less restrictive.

Other important principles to remember when assessing what are in an incapacitated person's best interests are:

- **Avoid discrimination** – do not make assumptions about somebody's best interest simply on the basis of their 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** – the decision must not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.
- **Take all of the above into account when making a best interest decision** both in relation to care and or consideration of treatment required.

8.7 Acts in Connection with Care and Treatment

Section 5 of the Act allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. This section provides possible protection for actions carried out in connection with care or treatment for a person who is believed to lack capacity to consent to the action, providing it is in the persons best interests to do so. Examples of actions included are:

- Help with washing, dressing or personal care
- Help with eating and drinking
- Help with mobility and communication
- Helping someone to take part in an activity
- Carrying out diagnostic examinations
- Taking someone to hospital for treatment
- Providing nursing care
- Providing care in an emergency

Section 5 does not apply where there are disputes about capacity or best interests, and does not provide protection in cases of negligence or depriving a person of their liberty.

8.8 Use of Restraint

Restraint could be undertaken in the best interests of the person and needs to be fully understood when working with people who lack capacity. Restraint can in some circumstances be considered a 'proportionate response' as this can be the least intrusive intervention, for example holding a person to undertake tests such as taking blood rather than giving medication to sedate the person in order for treatment to be carried out.

Restraint should only be used when the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and the restraint used will be proportionate to the likelihood and seriousness of the harm. On occasions when the use of force may be necessary, staff should use the minimum amount of force for the shortest possible time. Although section 6 MCA 2005 permits the use of restraint where it is necessary under the above conditions, section 6(5) MCA 2005 confirms that there is no protection under the MCA 2005 for actions that result in someone being deprived of their liberty.

These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action and that the action is in the best interests of the person.

Making these decisions via a multi-disciplinary team, which is then written into a person's care plan will provide protection to all, ensuring that at all times an assessment of the persons capacity to consent to the actions covered by the care plan is undertaken, with the confirmation that the actions to be taken are in the persons best interests.

Physical Restraint Policy M-012
Use of Force Policy OP-004

8.9 Ill Treatment or Wilful Neglect – a Criminal Offence

The MCA 2005 has a criminal offence of ill treatment or neglect of a person who lacks capacity by anyone responsible for that person's care, donees of Lasting Power of Attorney, or Enduring Power of Attorney, or deputies appointed by the court. There is no specified lower age limit. Any person found guilty of such an offence may be liable to imprisonment of up to five years.

8.10 Payment for Goods and Services

Staff should be aware that previous legislation and common law rules have now been brought together by the MCA 2005 regarding a person lacking capacity and the purchase of 'necessaries' in terms of goods and services. The MCA 2005 makes it clear that a person lacking capacity must pay a 'reasonable price' for goods and services supplied to them. A person who is acting under section five MCA 2005 may arrange something for a person's care or treatment and promise that the person receiving the care and/or treatment will pay for it. This is restating the common law rules which provide that a person acting as an 'agent of necessity' should not be out of pocket for acting in good faith.

The MCA 2005 does not provide a person acting for an individual lacking capacity to access that individual's bank or building society account. Formal steps may be taken to arrange this i.e. registering a power of attorney or obtaining a court order.

8.11 Independent Mental Capacity Advocate

The role of the Independent Mental Capacity Advocates (IMCA) is to support and represent individuals who lack capacity where the incapacitated person has no one else to support them (other than paid staff), to support or represent them or to be consulted. Within Humber NHS Foundation Trust the IMCA service is provided by Cloverleaf (Hull) and VoiceAbility (East Riding). A request for an IMCA must be done via the local authority who will arrange funding. An IMCA must be instructed, and then consulted, for people lacking capacity who have no one else to support them (other than paid staff), whenever:

- An NHS body is proposing to provide serious medical treatment; or

- An NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital (where the hospital stay will be longer than 28 days) or a care home (where the care home stay will be more than a weeks).

They may also support someone who lacks capacity to make decisions concerning:

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

Their role is to support the person who lacks capacity and to represent their views and interests to the decision maker. IMCAs therefore have the right to see relevant health care and social care records. Any information or reports provided by an IMCA must be taken into account as part of the process of deciding whether a proposed decision is in the incapacitated person's best interest. The IMCA's role will include interviewing the person who lacks capacity, if possible, as well as examining relevant health and social care records, plus obtaining the views of professionals providing care or treatment for the person who lacks capacity and obtaining the views of anyone else who can give information about the wishes, feelings, beliefs or values of the person who lack capacity. The IMCA should also consider whether obtaining another medical opinion would help the person who lacks capacity and must write a report on their findings for the NHS body or Local Authority concerned. If staff believe it may be necessary to involve an IMCA in a particular case, this should be discussed with their line manager.

The role of an IMCA is different to that of an Independent Mental Health Advocate (IMHA) which is appointed for those detained under the Mental Health Act 1983.

8.12 Lasting Powers of Attorney (LPAs)

Any person aged 18 or over with capacity can appoint an attorney (or more than one attorney) to make decisions about their personal welfare and/or their property and affairs if they lose capacity to make such decisions themselves in the future. Under a Lasting Power of Attorney, the appointed person (known as the' Attorney' or 'Donee') can make decisions that are as valid as one made by the person granting the Power of Attorney (the 'Donor'). Lasting Powers of Attorney replace the Enduring Powers of Attorney which pre-existed the MCA 2005. Lasting Powers of Attorney can cover two different types of decision making:

- Property and affairs (including financial matters)
- Personal welfare decisions (including healthcare and consent to medical treatment)

In order to be valid, a Lasting Power of Attorney must:

- Be a written document set out in the form required by the MCA 2005
- Must be registered with the office of Public Guardian (OPG) before it can be used
- An unregistered LPA will not give the Attorney any legal powers to make a decision for the Donor
- The Donor can register the LPA whilst they are still capable, or the Attorney can apply to register the LPA at any time
- Donors can add restrictions or conditions to areas where they would not wish the Attorney to have power to act
- Attorneys are always required to follow the principles in the MCA 2005 and must make decisions in the Donor's best interests. Importantly, the decisions of an attorney about whether to consent to or refuse medical treatment will 'trump' that of the incapacitated person's clinical team.
- However, if healthcare staff disagrees with the Attorney's assessment of interest, they should consider obtaining a second opinion and should then discuss the matter further with the Attorney. If the disagreement cannot be settled, an application can be made to the Court of Protection which can decide where the individual's best interests lie. Whilst an application is being made to the Court of Protection, healthcare staff can give life sustaining treatment to prolong the Donor's life or to stop their condition getting worse

Even where the LPA include healthcare decisions, Attorneys do not have the right to consent to or refuse treatment in situations where:

- The Donor still has capacity to make the particular healthcare decision
- The Donor has made an Advance Decision to refuse the proposed treatment – unless the Donor made the LPA giving the Attorney the right to consent to or refuse the treatment after the Advance Decision was made
- A decision relates to life sustaining treatment unless the LPA document expressly authorises the Attorney to consent to or refuse life sustaining treatment
- The Donor is detained under the MHA 1983, in which case an Attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983 (although there is an exception for ECT treatment – see section 58A of the MHA 1983)
- LPAs cannot give Attorneys the power to demand specific forms of medical treatment that healthcare staff do not believe are necessary or appropriate.

8.13 Court-Appointed Deputies

A Court-Appointed Deputy may be appointed by the Court of Protection to make decisions on behalf of a person who lacks capacity. A Deputy may be appointed, for example, in cases where there is a need for ongoing personal welfare decisions to be made on behalf of the incapacitated person and there is no other way of settling the question of what is in their best interests, e.g. due to family disputes.

The Court-Appointed Deputy will be under an obligation to act in the incapacitated person's best interest.

As with Lasting Powers of Attorney, the decision of a Court-Appointed Deputy as to what is in the incapacitated person's best interest will 'trump' decisions of the clinical team. However, in cases of significant disagreement, the case may be referred to be Court of Protection (see below).

8.14 Court of Protection

The Court of Protection is a specialist court, setup under the MCA 2005, to deal with issues relating to decision making on behalf of people who lack capacity.
The powers of the Court of Protection include:

- Making declarations (i.e. rulings), decisions and orders about financial and personal welfare matters affecting people who lack capacity, or who are alleged to lack, capacity
- Appointing Deputies to make decisions for people who lack capacity
- Removing Deputies or Attorneys who act inappropriately

An application to the Court of Protection may be necessary where there is genuine doubt or disagreement about a person's capacity or about what is in their best interests. The Court of Protection can also make decisions about the validity and applicability of Advance Decisions where this is in doubt.

Cases involving any of the following specific decisions should also be brought before the Court of Protection:

- Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from patients in a permanent vegetative state
- Cases involving organ or home marrow donation by a person who lacks capacity
- Cases involving proposed non-therapeutic sterilisation of a person who lacks capacity (e.g. for contraceptive purposes)

Prior to referring a matter to the Court of Protection, reasonable attempts should be made to resolve differences of opinion between professionals, or between staff and family members. Consideration should be given, for example, to:

- Obtaining an independent second opinion

- Holding a case conference involving staff and family members

9 EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

10 IMPLEMENTATION/TRAINING

This policy will be disseminated by the method described in the Document Control Policy.

MCA 2005 training is available for all clinical staff either via e-learning or bespoke face to face sessions where requested, and is mandated for certain staff groups working directly with patients and service users (see below).Humber Teaching NHS Foundation Trust has a compliance target of 85% for mental capacity training which is monitored monthly.

All Humber Teaching NHS Foundation Trust staff should complete level one MCA 2005 Awareness Training (e learning).

All clinical staff should complete Level 2 MCA 2005 (e learning and bespoke face to face sessions)

11 MONITORING AND AUDIT

Monitoring of appropriate use of the MCA is observed via the MCA audit in MyAssurance.

12 REFERENCES/EVIDENCE

Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007.

Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. 2008.

Mental Health Act Code of Practice 2015.

13 RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Deprivation of Liberty Safeguards Policy
Mental Health Act Policy
Safeguarding Adults Policy
Safeguarding Children Policy
Consent Policy

14 RELEVANT LINKS

- MCA - Booklet for Staff – introduction to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
- MCA – Mental Capacity Assessment Form
- MCA – Best Interests Decision Record
- MCA –Decision Making Pathway
- MCA – Best Interest Pathway

Appendix A: Policy Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Mental Capacity Act and Best Interests Decision Making Policy		
Document Purpose	The policy details the process of the Mental Capacity Act and best interests decision making for the Trust		
Consultation/ Peer Review:	Date:	Group / Individual	
List in right hand columns consultation groups and dates	Feb-23	Mental Health Steering Group Care Groups	
Approving Committee:	MHLC (V1.0)	Date of Approval:	February 2017
Ratified at:	Trust Board	Date of Ratification:	March 2017
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Mental Capacity Act Training is available for all clinical staff via the training diary. The member of staff requirement to undertake the training should be identified via the Trust Annual Performance Appraisal Development Review process. HTNFT has a compliance target for MCA training which is monitored monthly.	Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	• Ratified policy will be uploaded to Trust intranet • Staff will be informed of changes through Trust Midweek Global • Teams will be responsible for implementation		
Monitoring and Compliance:	Monitoring of appropriate use of the MCA/DoLS will be undertaken by the Mental Health Legislation Steering Group on a six-monthly basis and any findings shared with the Mental Health Legislation Committee.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
Draft	*New Policy*	*Oct 17*	*New policy for Code requirement*
1.0		*Nov 17*	*Approved QPaS Group*
1.2	*Minor amendment*	*Nov 18*	*Amendment to Appendix 2 to update the form*
1.3	*Update*	*Feb 20*	*Amendments made to update the policy in line with reviewing timescales.* *Approved at QPaS Feb 2020.*
1.4	*Update*	*March 2023*	*Amendments made in line with reviewing timescales. Full review/update to take place on release of Mental Capacity (Amendment) Act 2019 Code of Practice* *Approved at QPaS 16-Mar-23*

Appendix B: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name **Mental Capacity Act 2005 and Best Interests Decision Making Policy**
2. EIA Reviewer: **Rosie O'Connell, Head of Safeguarding, Trust HQ**,
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service

The purpose of this policy is to provide staff working in or with Humber Teaching NHS Foundation Trust with guidance about the Mental Capacity Act 2005. It sets out the main provisions of the Act, identifies the duties placed on health and social care staff and provides a procedure to determine the circumstances in which the various processes described within the Mental Capacity Act should be followed.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**LOW**	MCA can affect all age groups but would not apply to those under 16 years old. The highest proportions of those affected by the MCA process are those in older person's services, but anyone can have a need for capacity to be assessed in different circumstances. There is currently a clear process and guidance for assessment for staff and a full training programme which is above compliance levels.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**LOW**	Staff have full training in assessing capacity and supporting those who lack capacity with advocacy and IMCA where required. Training levels are compliant throughout the Trust. Learning disability services have a high proportion of service users who may lack capacity at times and there is evidence of a thorough awareness of the process and the need to provide good support and access to advocacy in this area.
Sex	Men/Male Women/Female	**LOW**	MCA 2005 is gender neutral and all measures are taken to ensure that all genders are supported through the MCA process and their specific needs considered.
Marriage/Civil Partnership		**LOW**	There is no evidence that this area is impacted on by the MCA 2005 process

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Pregnancy/ Maternity		**LOW**	All specialist support is provided to any individual who is experiencing problems regarding capacity and there are links with children's safeguarding and maternity services for specialist advice.
Race	Colour Nationality Ethnic/national origins	**LOW**	The MCA process always recognises specific needs of any ethnic or national groups and staff provide whatever specialist support is required. This could include family support, access to interpreters, advocacy and specialist support.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**LOW**	During the MCA process there should always be consideration of religious beliefs or lack of belief and staff will identify what support is required in these areas.
Sexual Orientation	Lesbian Gay men Bisexual	**LOW**	Any sexual orientation issues will be identified and appropriate support given during the MCA process. Specialist support will be identified where required.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**LOW**	When gender reassignment or transgender issues are identified staff will offer a safeguarding review as part of the MCA process and the Trust has a Supporting Transgender Patients Policy (N-060) in place.

Summary

The Trust has above compliance ratings for MCA training.

Advocacy and the IMCA process are available when required and staff evidence their awareness of this process Trust-wide.

An MCA audit has just been completed and we are aware of the knowledge and understanding of staff in the MCA 2005 and the process.

All staff are trained to level one throughout the Trust and have access to on-line leaflets for MCA awareness.

There is currently now a new transgender policy under review which will include the views of the LGBT community via their forum.

EIA Reviewer: **Rosie O'Connell**	
Date completed: **10 February 2023**	Signature: **R O'Connell**