NHS
Newcastle Gateshead
Clinical Commissioning Group

Corporate	CCG CO10 Mental Capacity Act Policy

Version Number	Date Issued	Review Date
V1: 23/10/2014	28/01/2015	31/10/2017

Prepared By:	Newcastle Gateshead Alliance Safeguarding Adults Team
Consultation Process:	Governance Lead, NHS South of Tyne and Wear Information Governance Advisor, NHS Tees Senior Manager, Corporate Affairs, NHS North of Tyne
Formally Approved:	25/11/2014

Policy Adopted From:	NHS County Durham and Darlington
Approval Given By:	Joint Governing Bodies

Document History

Version	Date	Significant Changes
V2	20/10/2014	Update and validity of ADRTs

Equality Impact Assessment

Date	Issues
6 February 2013	See section 9 of this document

POLICY VALIDITY STATEMENT
This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Mental Capacity Act Policy

Contents

Appendices

Mental Capacity Act Policy

1. Introduction

The Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The purpose of the Mental Capacity Act 2005 (MCA) for CCGs is in relation to commissioner's duties to ensure provider services are delivered in accordance with the MCA and that the rights of those who use services are promoted and protected. The CCG has responsibility for commissioning high quality care and treatment. The CCG must ensure providers understand the MCA, apply it to practice and monitor compliance.

Fundamentally the CCG will want to ensure;

- The MCA is given a high profile and priority within the CCG
- Compliance and who this will be achieved is a key part of the tendering process
- Ongoing compliance is monitored in detail through performance review and quality monitoring processes.

The main policy covers the areas outlined in the Department of Health Code of Practice, whilst Appendix b offers procedural guidance for those staff who may be required to justify any actions and interventions.

There is also a process flowchart attached offering a quick overview of the process at Appendix a.

The governing bodies and accountable officers of the CCG are committed to the development of a just and fair "no blame" culture, and this document supports that ethos.

The preparation of this document has included an assessment of risk covering clinical, financial, business and operational risks arising specifically from the implementation of the procedures described herein.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to

ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

To outline the responsibilities of the CCG in applying the Mental Capacity Act Code of Practice, with regard to ensuring that as Commissioners of services, these responsibilities are also adopted by those that we commission services from.

To assist practitioners in determining whether a vulnerable adult lacks capacity, how to establish this, what action to take, how to make decisions when a person lacks capacity and when to involve an Independent Mental Capacity Advocate (IMCA).

To set out the ways that staff will be expected to demonstrate that they have taken proper action when taking 'best interest' decisions for various levels of decision-making.

2. Definitions

The following terms are used in this document:

2.1 The following terms and abbreviations are used within this document:

Reference	Abbreviated Term
Mental Capacity Act	MCA
Mental Health Act	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	CoP
Lasting Power of Attorney	LPA
Enduring Power of Attorney	EPA
Advance Decision to refuse treatment	ADRT
General Practitioner	GP

2.2 Definition of Mental Capacity

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

An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem

- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- The effects of drugs and/or alcohol
- Delirium

Lacking capacity is about a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

Lack of Capacity must be established following the processes outlined in Appendix B.

2.3 Equality and Diversity Lead

Newcastle North and East CCG	Safeguarding Adults Officer
Newcastle West CCG	Safeguarding Adults Officer
Gateshead CCG	Safeguarding Adults Officer

3. Mental Capacity Act Principles

3.1 The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- You have observed the principles of the MCA
- You have carried out, or been party to, an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in questions **and**;
- You reasonably believe the action you have taken is in the best interests of the person

3.2 Provided you have complied with the MCA in assessing capacity and acting in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment

- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA))
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay under the common law doctrine of necessity/emergency.
- Placements in residential care

3.3 There are five key principles underpinning the MCA as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not unable to make a decision unless all steps have been taken unsuccessfully.
3. A person is not unable to make a decision merely because he makes an unwise decision.
4. An act/decision made behalf of a person who lacks capacity must be in his best interests.
5. Before the act or decision, ensure it is achieved in the least restrictive way.

3.4 The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, **a person must be aged 18 or over.**

The Act also introduces new bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate (section a)
- The Office of the Public Guardian (section b)
- The Court of Protection (section c)
- Advance Decisions to refuse treatment (section d)
- Lasting Powers of Attorneys (section e)

3.5 The Independent Mental Capacity Advocate (IMCA)

3.5.1 Advocacy is taking action to help people:

- Express their views
- Secure their rights
- have their interests represented
- access information and services
- explore choices and options

3.5.2 Advocacy promotes equality, social justice and social inclusion. Therefore an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

3.5.3 Referrals to an IMCA **MUST** be considered when:

- There needs to be a decision relating to serious medical treatment.
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home)
- A long-term move to different accommodation is being considered for a period of over 8 weeks and **MAY** refer when;
- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

3.5.4 If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. If it is urgent then the decision can be taken without an IMCA but they must be instructed afterwards.

3.5.5 If, after consultation with your line manager, you consider appointment of an IMCA would be of particular benefit to an individual then a referral must be made as outlined within appendix b.

3.5.6 It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker, nor are they mediators between parties in dispute.

3.5.7 The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker.

3.6 The Office of the Public Guardian (OPG)

3.6.1 This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the COP, as requested.

3.6.2 The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. Application to search the registers costs **£25.00**

3.6.3 Further information regarding the Office of the Public Guardian can be found by the following link:

http://www.publicguardian.gov.uk/

3.7 The Court of Protection (CoP)

3.7.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

3.7.2 The Act provides for a new CoP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (set examples to follow in future cases).

3.7.3 The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- appoint deputies to make decisions for people lacking capacity to make those decisions;
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties,
- and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

3.7.4 Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.

3.7.5 Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:

http://www.hmcourts-service.gov.uk/HMCSCourtFinder/

3.7.6 It must be stressed that any reference to the Court of Protection must be discussed with the Equality & Human Rights service in the first instance. The CCG must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. This is outlined in Appendix b.

3.8 Advance Decisions to Refuse Treatment (ADRT)

3.8.1 People may have given advance decisions regarding health treatments, which will relate mainly to medical decisions, these should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP. and are legally binding if made in accordance with the Act.

3.8.2 Making an advance decision to refuse treatment over the age of 18 years allows particular types of treatment you would never want, to be honoured in the event of losing capacity – this is legally binding and doctors etc. must follow directions.

3.8.3 You must take all reasonable efforts to be aware of the advance decision and that it exists, is valid and applicable to the particular treatment in question.

3.8.4 The Act introduces a number of rules you must follow. Therefore a person should check that their current advance decision meets the rules if it is to take effect.

3.8.5 An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive and without they may die) this must be in writing.

3.8.6 Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. You cannot ask for an advance decision to end your life or request treatment in future.

3.8.7 The validity of an advance decision may be challenge on the following grounds;

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act is the criteria for admission are met.
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision

3.9 Lasting Powers of Attorney (LPA)

3.9.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters

- Personal Welfare LPA re decisions about health and welfare, where you live day to day care or medical treatment.

This must be recorded in the person's file where there is knowledge of it. It only comes into effect after the person loses capacity and must be registered with the Office of the Public Guardian. An LPA can only act within the remit of their authority.

3.9.2 Important facts about LPAs

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes an LPA they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

3.10 Clinical Intervention

3.10.1 Decisions that are not covered by the MCA:

- Making a will
- Making a gift (unless they have a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering in to marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office

3.10.2 There must always be an assumption of capacity; however procedural guidance at appendix b tells a practitioner what to do if it is suspected that a vulnerable person has a disturbance in the function of the mind or brain and may lack capacity to make a decision at this particular time. The second test, often referred to as the Functional Test, supports assessors to determine whether or not the patient can make the decision or lacks the mental capacity to do so.

3.10.3 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf, as long as they decisions they make are within their job remit.

3.10.4 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation.

3.10.5 Practitioners have to show that they

- have followed the five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity,
- have enabled a person, so far as is possible, to make their own decisions
- have taken reasonable steps to establish lack of capacity,
- have reasonable belief that the person lacks capacity,
- have demonstrated their action will be in the person's best interest.

3.10.6 Section 5 of the Act offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity, provided they have followed due process. Appendix b covers the procedure required.

4. Duties and Responsibilities

Council of Members	The council of members has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Accountable Officer	The accountable officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
Equality and Diversity Lead	The equality and diversity lead is responsible for: • Maintaining and reviewing this policy document. • Updating this policy when required • Monitoring the implementation of this policy
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

5. Implementation

5.1 This policy will be available to all Staff for use in the circumstances described on the title page.

5.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. Training Implications

The training required to comply with this policy are:

- Policy awareness sessions
- Mandatory training programme
- E-learning
- Multi-Agency training is available from the Local Authority
- Bespoke training is also available from the Safeguarding Adults Team

7. Documentation

7.1 Other related policy documents.

Guidance on Advance Decision to Refuse Treatment (ADRT)

Safeguarding Vulnerable Adults Policy.

7.2 Legislation and statutory requirements

Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.

Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.

Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.

Cabinet Office (2006) *Equality Act 2006.* London. HMSO.

Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.

Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.

Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.

House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office

7.3 Best practice recommendations

Department of Health. (2006) *Records Management: NHS Code of Practice.* London: DH.

NHS Litigation Authority. (2008) *Risk Management Standard for Primary Care Trusts.* London: NHSLA.

NHS England (London) (April 2014) Mental Capacity Act 2005: A guide for Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance. London: NHS England

HM Government (June 2014) Valuing Every Voice, respecting every right: Making the Case for the Mental Capacity Act. The Government's response to the House of Lords Select Committee report on the Mental Capacity Act 2005. Lord Chancellor and Secretary of State for Justice and Secretary of State for Health

Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

Ruck Keene, Alex and Dobson, Catherine (April 2014) Mental Capacity Law: Guidance Note. Deprivation of Liberty in the Hospital Setting. London: 39 Essex Street

Social Care, Local Government and Care partnership (2014). Positive and Proactive Care: Reducing the need for restrictive interventions. London: Department of Health

Social Care Institute for Excellence (august 2014) Adult Services: Report, Deprivation of Liberty Safeguards: putting them into practice. London: www.scie.org.uk

8. Monitoring, Review and Archiving

8.1 Monitoring

The governing body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

8.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

9 Equality Analysis

Equality Analysis Screening Template

Title of Policy:	CCG CO10 Mental Capacity Act Policy
Short description of Policy (e.g. aims and objectives):	To outline the responsibilities of the CCG in applying the Mental Capacity Act Code of Practice, with regard to ensuring that as Commissioners of services, these responsibilities are also adopted by those that we commission services from. To assist practitioners in determining whether a vulnerable adult lacks capacity, how to establish this, what action to take, how to make decisions when a person lacks capacity and when to involve an Independent Mental Capacity Advocate (IMCA) To set out the ways that staff will be expected to demonstrate that they have taken proper action when taking 'best interest' decisions for various levels of decision-making.
Directorate Lead:	
Is this a new or existing policy?	New

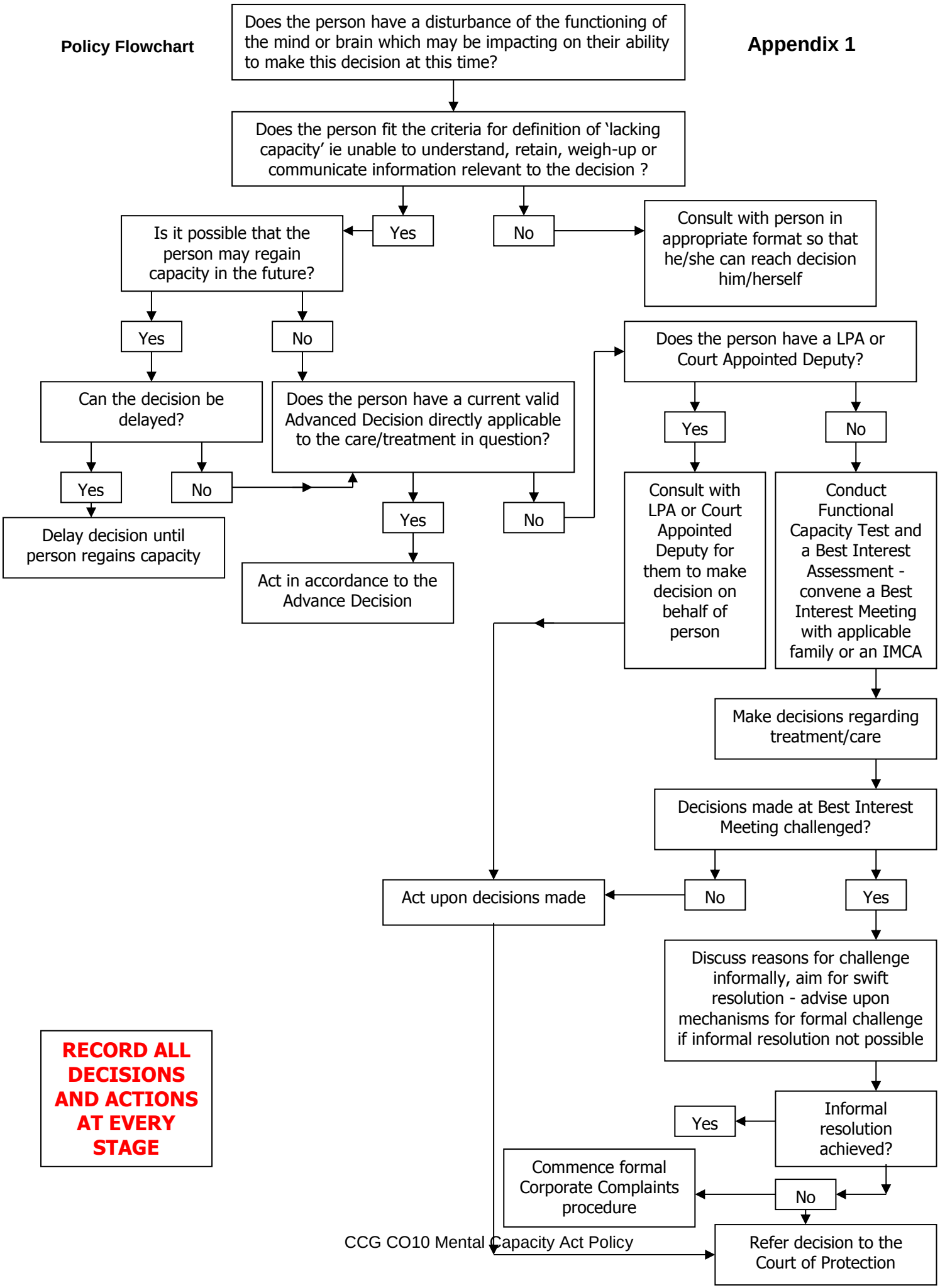
Equality Group	Does this policy have a positive, neutral or negative impact on any of the equality groups? Please state which for each group.
Age	Neutral
Disability	Neutral
Gender Reassignment	Neutral
Marriage And Civil Partnership	Neutral
Pregnancy And Maternity	Neutral
Race	Neutral
Religion Or Belief	Neutral
Sex	Neutral
Sexual Orientation	Neutral
Carers	Neutral

Screening Completed By	Job Title and Directorate	Organisation	Date completed
Jeffrey Pearson	Policy and Corporate Governance Lead	NHS County Durham and Darlington	6 February 2013

Directors Name	Directors Signature	Organisation	Date

Policy Flowchart

Appendix 1



Appendix 2

Procedural Intervention

1. Introduction

1.1 When a person is in your care and needs to make a decision you must assume that person has capacity and make every effort to support and encourage the person to make the decision themselves. Also remember that people can make unwise or eccentric decisions, but this does not mean they lack capacity.

1.2 This could include:

- Does the person have all relevant information?
- Could the information be explain or shown more easily?
- Are there particular times of the day when a person's understanding is better?
- Can anyone else help to support the person?

1.3 Every effort must be made to encourage and support a person to make a decision for themselves. If this is difficult, an Independent Mental Capacity Advocate (IMCA) is a new service offering a specific type of advocate that will only be involved if there is no-one else appropriate and in specific situations such as:

- Decision about serious medical treatment
- Decisions about moving into long term care – 8 weeks +
- The IMCA will obtain and evaluate relevant information
- Discuss the proposed decision with professionals and others concerned
- Find out as far as possible their wishes and feelings
- Consider making alternative courses of action
- Get further medical opinion where necessary
- Provide a report with submissions for the person making the decision

1.4 When there is reason to believe a person does lack capacity at this time consider:

- Has everything been done to help and support the person?
- Does the decision need to be made without delay?
- Is it possible to wait until the person has the capacity to decide without causing further harm?

1.5 If the person's ability to make a decision still seems questionable then you will need to assess capacity.

2. Decision Making

2.1 The person responsible for undertaking the capacity test is usually the **Decision Maker** though they should consult everyone involved in the decision**.** The Decision Maker will be the person who will carry out the act/treatment proposed or who will delegate the act to a colleague. For example, a GP asks a District Nurse to administer insulin. If in doing so, the District Nurse feels the person's blood sugars are low then they should use their own professional judgement and report back to the GP. The Decision Maker should be the most appropriate person in relation to the type of decision involved and their professional remit. Therefore different people will be involved in assessing a person's capacity at different times and for the CCG they will be a **qualified professional** as follows:

- Qualified Nurses
- Physiotherapists
- Occupational Therapists
- Other Allied Health Professionals
- GPs

2.2 However, if a person has a Lasting Power of Attorney or Court Deputy then that person would act as the decision maker within the remit of their legal powers. For example finance and property or health and welfare or both if stated.

2.3 It is important to consider the following:

- What is the Decision that needs to be made?
- Who will be involved generally?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?

2.4 You should consider the following prompts prior to decision making:

- The environment is appropriate where it is quiet and uninterrupted.
- The person has the relevant information and in a format that they can understand? Do not burden the person with more detail than necessary.
- Could it be explained in an easier way and do you need help from other people for example a Speech and Language Therapist or an Interpreter to help with any issue of communication?
- Is this the right moment or place to discuss this, does the person seem comfortable discussing this issue now?
- Can anyone else assist? Consult with family and other people who know the person well.
- Does the decision have to be made now? Try to choose the best time for the person and ensure that the effects of any medication or treatment are considered.
- Can this wait until the person has capacity if the loss is temporary?

- Be aware of cultural factors, which may have a bearing on the individual. Consider whether an advocate is required.
- Take it easy. Make one decision at a time.

2.5 You must always follow the five key principles of the MCA in any decision-making and assess at a person's best level of functioning for the decision to be taken.

2.6 The MCA states that "assessment of capacity to take day to day decisions or consent to care require no formal assessment procedures". However although day-to-day assessments of capacity may be informal, they should still be written down by staff. Therefore if an employee's decision is challenged, they must be able to describe why they had a reasonable belief of a lack of capacity. Therefore recording should always be inserted within a patient's case notes or care plan.

2.7 In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear and recorded process. In order to achieve this a Record of Capacity Test and Best Interests Assessment form (MCA 1) must be completed – attached at ANNEX A.

3. How to determine if someone lacks mental capacity:

3.1 The starting point is the assumption that the person can make the decision for themselves. If you have reason to doubt then follow the guidance below:

- The assessment of capacity must be date, time and issue specific, complex decision may involve a series of smaller decisions
- If someone cannot make a complex decision, don't assume they cannot make a simple decision
- You cannot decide someone lacks capacity based on his or her appearance, age, condition or behaviour alone.
- Can the decision wait until the person regains capacity and is it safe to delay the decision/

3.2 In order to decide a person has the mental capacity to make a decision you must decide whether there is an impairment or disturbance in the functioning of the person's brain – whether permanent or temporary.

3.3 If so the second question is does the impairment/disturbance make the person unable to make that particular decision at the time it needs to be made? The person will be unable to make a particular decision after all appropriate help and support to make the decision has been given to them they cannot:

- **Understand** the information relevant to the decision including the likely consequences of making or not making the decision.
- **Retain** the information
- Use or W**eigh up** the information as part of the decision making process
- **Communicate** their decision by any means

3.4 An assessment must be made on the balance of probabilities and you should be able to demonstrate in your records why you have come to that conclusion.

3.5 Sometimes your assessment may be challenged by another person acting for the individual such as a family member or advocate. Seek resolution in the following ways:

- Raise the matter with the person who made the assessment and check records.
- A second opinion may be useful.
- Involve an advocate but not an IMCA.
- Local complaints procedure.
- Mediation
- Case conference
- Ruling by Court of Protection

3.6.1 Further guidance for completing this section is attached at ANNEX B.

4. Best Interests Assessment

4.1 If a person has been assessed as lacking capacity to make that decision then the decision made for, or on behalf of, that person, must be made in his or her best interests. A best interest's decision must be objective; it is about what is in the person's best interests and not the best interests of others. Best interest is wider than what is medical best practice.

4.2 The decision maker must weigh up all the factors involved, consider the advantages and disadvantages of the proposals and determine which course of action is the least restrictive for the person involved. This includes consideration of restriction or deprivation of liberty. (see Deprivation of Liberty Safeguards Policy)

4.3 By best interests we mean:

- The decision maker has considered all relevant circumstances, including any written statements made while the patient had capacity must also be taken into account and any other information relevant to this decision
- Equal consideration and non-discrimination – consider the view of all involved not just those who agree with your preferred option.
- Do not to make an assumption that a decision is made merely on the basis of a person's age or condition,
- The decision maker has considered whether the person is likely to regain capacity – can the decision be put off until then and is there any advantage in doing so?
- Permitting and encouraging participation - the person has been involved as fully as possible in the decision, with the appropriate means of communication or using other people to help the person participate in the decision making process. Healthcare professionals are therefore required to make enquiries of relatives, carers and friends

of the patient. Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be taken into account if the person had capacity, and to take into account, if practicable and appropriate the views of people who have formally or informally been involved with, or named by, the incapacitated person.

- Special considerations for life sustaining treatment - the decision maker is **NOT** motivated by a desire to bring about the person's death.
- Taking into account the views of anyone involved in caring for the person, any IMCA, any Attorney appointed by the person or any Deputy appointed by the Court of Protection.
- Consider whether there is a less restrictive alternative or intervention that is in the person's best interests.

4.4 When determining someone's best interests you must be able to demonstrate:

- That you have carefully assessed any conflicting evidence and
- Provide clear, objective reasons as to why you are acting in the person's best interests.

4.5 As far as possible try to ascertain:

- Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care?
- If practicable and appropriate you must consult with, and take in to account, the views of the following:
  - A Nominated Person
  - Lasting Power of Attorney appointed
  - Enduring Power of Attorney appointed
  - Court Appointed Deputy
  - Other persons engaged in caring for, or interested in, the person.

4.6 For significant decisions, a Best Interest Meeting will need to be arranged with all relevant consultees.

4.7 Therefore, in order to achieve a Best Interests Assessment you must continue at Section 3 of the Record of Capacity Test and Best Interests Assessment form (MCA 1), which is attached at ANNEX A.

4.8 Further guidance for completing this section is attached at ANNEX C.

4.9 Guidance on holding a Best Interests Meeting is attached at ANNEX D.

5. Challenging the Result of an Assessment of Capacity or Best Interests Decision

5.1 Your assessment of capacity may be challenged. It is important that everything you do is carefully documented.

5.2 It may be challenged in the following ways

- Raised directly with you
- Request for a second opinion
- Involving an advocate – NOT an IMCA
- Complaints procedure
- Court of Protection

5.3 **However** every effort should be made to resolve disagreements as informally as possible. Of importance are the following:

- How robust is the risk assessment?
- Has everything been recorded?
- Degree of 'contentiousness' of best interest decision between those involved in the person's care, i.e. the level of disagreement by family or IMCA as to proposed course of action?
- Is there a possibility of conflict of interest between family members and person, e.g. over finances?
- Urgency with which decision needs to be made?
- Degree to which decision/intervention can be reversed (undone)? The more irreversible, the higher the level of consultation required. Potential risks to the person and implications if a decision is made, not made or not reversed, including where other dependents are involved (e.g. children)

5.4 The Code of Practice makes it clear that any dispute about the interests of a person who lacks capacity should be resolved in a quick and cost effective manner.

5.5 Where significant persons are involved in the person's life every effort should be made to consult with, and involve, them and arrive at an agreed decision provided this is felt to be in that person's best interests and meets their assessed social and/or medical needs.

5.6 Where agreement cannot be reached seek assistance from your line manager or a senior manager in this process, further meetings may be necessary including seeking legal advice.

5.7 If no agreement can be reached the family or carers have recourse to the CCG complaints procedures of the agencies involved.

5.8 Recourse to the Court of Protection should be the last resort if no agreement can be reached. The equality and diversity lead should be consulted at this stage.

MCA 1- Assessment of mental capacity

Name of the resident being assessed: _____

What is the decision *the patient* needs to make?

Does *the patient* have an impairment of or disturbance in the functioning of the mind or brain, please explain why you believe this to be the case?

Why do you feel this ***does/doesn't*** affect *the patient's* ability to make this decision at the time it needs to be made? [delete as appropriate]

Only proceed with the assessment if the patient does have an impairment of, or disturbance in the functioning of the mind or brain which you 'reasonably believe' is affecting their mental capacity to make this decision at the time it needs to be made. If not, please complete the outcome on page 3.

Does *the patient* **understand** information relevant to this decision?
Describe the reasons for your decision below.

Is *the patient* able to **retain** information relevant to the decision?
Describe the reasons for your decision below.

Is *the patient* able to **weigh-up** the information relevant to the decision?
Describe the reasons for your decision below.

Can *the patient* **communicate** their decision by any means?
Describe the reasons for your decision below.

Name of Assessor: _____

Job title: _____

Signature: _____

Consultees:

Name	**Role/Relationship**	**Contact Details**

Date Assessment completed: _____

Outcome of Assessment

The patient **has/hasn't** got capacity to make this particular decision [delete as appropriate]
Explain the reasoning for your decision below.

Date assessment will be reviewed: _____

Guidance to completing MCA1

What is the decision the patient needs to make?

Before you begin assessing the patient, make sure you are clear in your own mind exactly what the decision is. Is there one decision or several different decisions? Top Tip: Write the decision in one clear sentence. Avoid using jargon and phrase the question in language the patient will understand.

Does the patient have an impairment of, or disturbance in the functioning of mind or brain?

The Mental Capacity Act covers permanent, transient and temporary impairments of the brain. Permanent and transient conditions may include dementias, acquired brain injuries, learning disabilities or mental health problems. Temporary conditions may include deliriums and being under the influence of drugs or alcohol, or side effects of medication such as sedatives.

You do not need to have a formal diagnosis from a doctor, though that helps. Think about how you might gather such information? You could access information from paper and electronic files, such as assessments, care plans or letter from a consultant/GP. The type of medication someone is prescribed could provide a clue. Where the patient is could give a clue, for example, a resident is living in a dementia care unit. You can gain information from the patient, their family or care staff who know them well. Also, your own experience of working with service users may well help you spot the sign that a patient may be suffering from some form of mental disorder. **Remember**, you only need to have a reasonable belief that is that it is more likely than not the patient has an impairment of, or disturbance in the functioning of their mind or brain.

Why do you feel this **does/doesn't** affect the patient's ability to make this decision at the time it needs to be made?

Give a brief explanation of why you 'reasonably believe' the patient's impairment or disturbance in the functioning of their brain is affecting their ability to make this decision. An example may well be that the patient is behaving in an unusual manner and making decisions that would conflict with their usual decision making patterns etc. Be descriptive, examples can illustrate your assessment. Be careful not to make assumptions based purely on a patient's age, diagnosis or behaviour.

It may well be that you do not feel the patient's disturbance or impairment is affecting their ability to make this decision at this time. If that is the case, record your reasons. You must then conclude the resident has the mental capacity to make this decision. You do not need to complete the rest of the form. **Remember** that you can't overrule the decision the patient makes just because you feel the choice they have made is an unwise choice.

Does the patient **understand** the information relevant to this decision?

Ask yourself what information does the patient need to be able to make this decision. This should include all viable options and not just the option others feel is best for them. Some information about probable advantages and disadvantages of each option will also be invaluable.

Explain what efforts you have made to help the patient understand the information, such as using different media or rewording information? Be careful not to provide too much information. Avoid jargon and consider the resident's preferred method of communication. Also consider if there is anyone the patient trusts and would like to be present. Carefully consider the appropriate venue and timing of your assessment.

Is the patient able to **retain** information relevant to the decision?

How do you know if the resident has remembered the information? Firstly asking them to repeat it back to you can work but you need to be careful they are not just repeating it 'Parrot fashion'. You can ask them to summarise or paraphrase information. One handy hint is to ask the patient to explain what you have told them to someone else in your presence. You can then get a clear picture of how much information they have retained and how well they have understood it. **Remember** that the patient only needs to be able to retain information for long enough to be able to weigh it up and communicate their decision.

Is the patient able to **weigh-up** the information relevant to the decision?

Can they tell you the advantages and disadvantages of the options under consideration. This should include the option of doing nothing. Can they explain the consequences of their preferred option. **Remember** the patient does not have to give a rationale that you agree with, they need only demonstrate they can weigh-up the information.

Can the patient **communicate** their decision by any means?

What is the patient's preferred method of communication? The patient does not have to be able to articulate only indicate their preference. It may be a simple as pointing or indicating preference with a thumbs up or thumbs down. Be creative, and don't be afraid to ask obvious questions to ensure you have fully understood the choice the patient has made.

Name, Job Title and Signature of Assessor/Consultees

It should clearly identify who has carried out the assessment as well as detailing who was party to the assessment. Also state clearly the date upon which the assessment is completed.

Outcome of Assessment

State clearly whether you feel on the balance of probabilities the resident has or hasn't got capacity to make this decision at this time. Detail your rationale.

MCA2 - Best Interest Decision

Patient's Name: _____ D.O.B: _____

What is the decision you need to make on their behalf?

List all viable options:

Option	Advantages	Disadvantages

Are there any delegated decision makers? [please tick]

Lasting Power of Attorney – Welfare Remit Yes [ ] No [ ]
Lasting Power of Attorney – Financial Remit Yes [ ] No [ ]
Applicable Advanced Decision {ADRT} Yes [ ] No [ ]
Court Appointed Deputy Yes [ ] No [ ]

NB Only make the decision if none of the above have a remit to make this decision.

List of all parties consulted in making this decision:

Name	Role/Relationship	Contact Details

Does the person have family or friends appropriate to consult? If no, have you considered involving an Independent Mental Capacity Advocate (IMCA) met, please explain your rationale below?

What are the views of the person? Include any written statements or any similar previous decisions?

What are the views of the carer/family/ friends?

Name & Relationship	**Summary of their views**

What are the views of professionals involved in the person's care?

Name & Role	**Summary of their views**

Explain why the person will not regain mental capacity or why delaying could cause additional harm?

Explain how you have supported the person to be involved in the process and avoided discriminating against them:

Is this decision about life-sustaining treatment? Yes [ ] No [ ]
If yes ,explain below:

NB you must not be motivated by a desire to bring about their death

On what issues is everyone in agreement?

Are there any areas of disagreement?

State clearly the outcome of the decision you have made

Explain the rationale for your decision

What is your contingency plan?

Date of Best Interest Decision:	
Name of Decision Maker:	
Signature of Decision Maker:	
Date decision will be reviewed:	

Best Interest Decision CCG MCA 2 Guidance Tool

NB This guidance should supplement the guidance available in Chapter 5 MCA Code of Practice

What is the decision you need to make on their behalf?

Before making a decision on behalf of a person, you **must** believe that on the balance of probabilities, the person does not have the capacity to make the decision themselves. You should also record that capacity assessment on MCA 1. You should ask yourself if the decision needs to be made now or can it be postponed until the person regains capacity, for example, a person suffering from a Urinary Tract Infection may regain previous levels of capacity with the appropriate treatment. Otherwise continue to make the decision now if delay is likely to result in harm or significant loss to the person.

Be clear what the decision is you are trying to make. You may need to re-word the original question to read from your perspective, not that of the person.

Ask yourself if you are the appropriate person to take on the role of decision- maker. The decision-maker should be the person who is going to carry out the task/outcome of the decision. For example, medical decisions should only be made by staff with the appropriate professional training. Do not take on the role if the decision is outside your usual job remit. Similarly you do not have to carry out a task that you believe will cause harm to the person. An example would be you would not continue to give a prescribed laxative if the person is suffering from diarrhoea, you would seek appropriate medical advice.

Are there any delegated decision-makers?

Before taking on the role of decision-maker you must ensure that the person has not foreseen such events and appointed someone to make such decisions on their behalf. Enduring Power of Attorney [EPA] was replaced with Lasting Power of Attorney [LPA] by the Mental Capacity Act 2005 {implemented in 2007}. However, any EPA's registered before then will still be valid. A further note of caution is to remember that EPA and LPA (Financial Remit) only give the Donee powers to make decisions regarding the person's money and property. It does not grant them authority to make health and welfare decisions. Only an LPA (Welfare Remit) would allow the Donee to make healthcare and welfare related decisions. Before accepting that a relative or friend has power of attorney, ask to see a copy of the registration document and check the remit carefully. Please remember that if the Donee has a valid EPA or LPA then it is their decision to make and you can't override them. Similar rules apply to anyone who has gained the powers of a Deputy by applying to the Court of Protection. If you feel any delegated decision

maker is not acting in the best interests of the person you should report this to the CCG Safeguarding Adults Team.

Advance Decisions to Refuse Medical Treatment (ADRT) are only valid if made whilst the person had capacity. They are legally binding, though it is worth noting that only refusals of treatment are binding. Anything else are considered to be the wishes and feelings of the person. Please remember that these are still very significant and the decision-maker must have regard to them when making any decision on the person's behalf. ADRT's can be invalidated if you have evidence that they were made whilst the person lacked capacity or were made under duress. The Mental Health Act 1983 would also allow you to override a person's refusal of treatment for a mental disorder but not a physical disorder unrelated to their mental health diagnosis. ADRT's can also be invalidated if the person has made a subsequent inconsistent decision and changed their views without updating the ADRT. If the refusal of treatment would bring about the death of the person then further criteria are needed. It must be written down, contain a precise statement of what they are refusing, a written acknowledgement that such a refusal may bring about their death, be dated, signed and witnessed.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) notices should only ever be made by a doctor involved in the person's care. Guidance states they should only be put in place if the person's medical condition means that such an event is reasonably foreseeable and such attempts to prolong life would have little or no benefit to the person. Such decisions should be made in consultation with the family and should be reviewed regularly.

List all parties consulted in making this decision
Record the names of all of those people you have consulted with in making this best interest decision. State clearly, their professional role or relationship to the person. Ensure you have contact details should you need to clarify points at a later date or send out copies of the MCA 2.

When seeking the most appropriate people to consult, you should consider who knows the person best or is best able to communicate with the person. This is not always the most qualified person and may be the care worker who provides care on a regular basis. Further guidance can be obtained by following the Best Interest Checklist in Section 4 of the MCA. Please do not select only the people you feel will agree with your preferred outcome. It is healthy to record conflicting views as this can make us challenge our own assumptions, values and prejudices.

You should always strive to seek the views of family members, again being careful not to only ask those who will agree with us. Where the person does not have any family or friends with whom you can consult then you should consider the criteria for instructing an Independent Mental Capacity Advocate (IMCA). It is a legal duty to do so if making decisions about a change of accommodation for more than 6 weeks in a care home or 28 days in a hospital. An example might be moving a person from one care home to another. It is also a duty when the decision relates to Serious Medical Treatment, however it would usually be a doctor who would be the decision- maker in these circumstances. There is a power to instruct an IMCA if you are reviewing their accommodation or if you are concerned family may not be able or willing to represent the best interests of the person. Always record your reasons for either instructing or not instructing an IMCA.

What are the views of the person/any similar decisions?
Record carefully any views expressed by the person regarding the decision in question, even if you feel they lack capacity to make an informed choice. It may be possible to draw inferences from previous decisions the person made when they had capacity. For example, if the person regularly went to their GP for a 'Flu jab' then it would be a reasonable assumption they would have consented if they had capacity. It is worth bearing in mind, however that you are not duty bound to follow previous decisions only to have regard to them in coming to your own conclusion about what is in their best interests.

What are the views of…
In the next three sections you are asked to record the views of carers/family and friends and those of relevant professionals in coming to the conclusion you reach. These views do not have to all be in agreement. Differences of opinion are healthy and stimulate debate. Record a summary of their views relevant to the question being discussed. Ensure all Consultees have the necessary information to help them participate fully but be careful that you do not breach confidentiality unnecessarily. When taking account of the views of the patient, ensure you have taken into consideration all of the factors they would have seen as relevant to the decision, for example, caring commitment, religious beliefs, values and attitudes. Include any written information around their previous wishes and feelings.

Explain why the patient will not regain mental capacity or why delaying could cause additional harm?
In this section explain why you feel the person will, or won't regain the mental capacity to make this decision. For example, you may say the

person never had mental capacity around this decision due to a developmental delay or learning disability or that they have lost mental capacity due to a dementia or traumatic brain injury. If the person will regain mental capacity to make this treatment decision then you must justify any decision not to wait. For example, the person is suffering from a delirium which, with treatment would mean the person will regain capacity but in the mean time they are bleeding and need treatment to prevent further blood loss.

Explain how you have supported the person to be involved in the process and avoided discriminating against them:
What steps have you taken to allow the person to be involved in the treatment decision as much as is possible. For example, have you presented information in a different media, have you ensured they are in a quiet space away from distractions and that they have someone with them with whom they are comfortable. Be careful to evidence how you have ensured you have not made assumptions based on their age, disability or behaviours.

Is this decision about life-sustaining treatment?
If you are making a decision about withholding or withdrawing life-sustaining treatment you must evidence how you are not motivated by a desire to bring about the person's death. That does not mean you have to provide treatment which you believe to be futile or overly burdensome on the patient and provides no chance of recovery. Where there is disagreement about the withholding or withdrawal of life-sustaining treatment then take legal advice and consider an application to the Court of Protection for a declaration of best interests.

Areas of Agreement/Areas of Disagreement
Wherever there are disputes, it is always worth starting with the areas upon which all parties can agree. For example, you may all agree that you want what is best for the person. The following section covers those areas in which you can't all agree should be recorded. Be careful to record these fully and clearly state who it is that is in disagreement about what. You do not need universal agreement to reach a conclusion though every effort should be made to reach agreement to reduce the risk of legal challenges.

State clearly the outcome of the decision you have made?
Once you have reached a conclusion, you should state clearly and precisely what is the decision you have made and how it will be carried out. Include any transitional arrangement that may be necessary. Where

possible, seek agreement about how things will proceed and who will do what, by when.

Explain the rationale for your decision
Detail why you have made the choice you have made from the realistic options available. It is often easier to explain why you have made one choice over another by making comparisons between the two most viable alternatives. For example, you may state that a choice between two care homes of equal quality is made because one is closer to the person's family or friends. It is not always possible to make the best choice, e.g., resources may impact negatively upon your decision, often the best you can do is choose the least worst or least harmful choice.

What is your contingency plan?
Should your preferred choice not work out as planned, what is your back up plan. This should hopefully reduce the likelihood of having to go 'back to the drawing board' should something unexpected prevent your primary choice from being available or a change in circumstances renders your first choice as no longer being in the person's best interests.

Dates and Signatures
Always record the date upon which you made your final decision. If this decision was made over several contacts then it may be worth noting the dates of consultations in the section which deals with the views of those consulted. The MCA 2 form should always be signed by the decision-maker and clearly print their name for clarity. It is also useful to put the date when this decision will be reviewed, if this is foreseeable, to ensure it remains in the best interests of the person. It will not always be necessary to complete a new MCA 2 if all circumstances remain the same. Consider a fresh MCA 2 if there are significant changes.

Disclaimer
The guidance above should be read in conjunction with the MCA and its code of practice. Seek legal advice to ensure compliance with the act and subsequent caselaw.