Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005

Department / Service:	Corporate
Originator:	Worcestershire Safeguarding Adults Board(WSAB)
Accountable Director:	Paula Gardner Chief Nurse
Approved by:	Integrated Safeguarding Committee 1st June 2018 Updated version CGG 19th April 2022 (Chair approval)
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All

Policy Overview:
To ensure staff are aware of, and comply with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice.

Latest Amendments to this policy:
Full adoption of the Worcestershire Safeguarding Adult Board Policy /Procedure – Mental Capacity Act 2005 - Guidance and Policy for Staff. Approved Safeguarding Committee 1st June 2018
May 2021 – Revision and update by Worcestershire Safeguarding Adults Board – ratified August 2021. Ratified by CGG April 2022.

Document Control

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- **To be reviewed** August 2024

Revision History

Date	Version	Changes made	Author
March 2017	V2.1	Grammatical, typo, consistence and factual accuracy corrections Change in emphasis from assume capacity to check if right to assume capacity Defining serious medical treatment More detail added to appendix 1 flow chart Removal of appendixes 2 – 5; documents to be held on intranet separately MCA1 Form – Capacity Assessment MCA2 Form –Best Intererst Assessment and Record of Actions Onside Advocacy Leaflet Onside IMCA Referral Form MCA 1 & 2 included in the definitions	Suzanne Hardy
April 2017	V2.2	Amendments to make causative nexus test explicit in policy and appendix 1 Information on how to check a LPA	Suzanne Hardy and Jason Marshall
April 2017	V2.3	Removal of reference to MCA Steering Group Rewording of groups covered by policy	Suzanne Hardy
June 2017	V2.4	Rewording of Informal Decisions section	Richard White
April 2021	V2.5	2f, 6f amended and additional minor amendments	Jason Marshall and Mike Wood
August 2021	V3	Ratified by Chairs	

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Location: www.worcestershire.gov.uk/wsab

Acknowledgements

This document supports the West Midlands Safeguarding Adults Policies and Procedures.

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Appendices

1. Introduction

a. The Mental Capacity Act 2005 (MCA) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to prepare for a time when they may lack capacity in the future. The Act makes clear who can take decisions, in which situations and how they should go about this.

b. The underlying philosophy of the MCA is to ensure that individuals who lack capacity are the focus of any decisions being made, or actions taken, on their behalf. This requires an individual approach that prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person.

c. The MCA is accompanied by a Code of Practice which explains how the Act works. The Code of Practice provides guidance to everyone who is working with and/or caring for adults who may lack capacity to make particular decisions. It should be used as guidance rather than instruction. However if the relevant guidance contained in the code is not followed then staff will be expected to give good reasons why they have departed from it. Staff may then be asked to account for that non-compliance in a court of law, tribunal or through any abuse investigation.

d. People who work in health and social care such as doctors, nurses, psychologists, occupational, speech and language therapists, social workers, residential and care home managers, care staff (including domiciliary care workers), support workers (including people who work in supported housing) and any other health and social care workers will be affected by the MCA and need to know about it. This will include personal assistants employed via Direct Payments.

e. The MCA introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity. If convicted, people can be imprisoned or fined.

f. The Code of Practice and this policy clearly describe roles and responsibilities for staff when acting or making decisions on behalf of individuals who lack capacity to act or make decisions for themselves.

2. Purpose

a. The purpose of this policy is to inform staff working in the statutory and independent sectors in Worcestershire about the local arrangements for working with patients/users of services over the age of 16 with impaired mental capacity.

b. It is designed with the aim of consolidating the information and documentation available to staff on a county-wide basis.

c. This document sets out the procedures for all staff to follow in assessing capacity and making best interests decisions and provides templates for recording these.

d. The decision in Worcestershire, in line with the spirit of the MCA, is not to restrict capacity assessments to specified groups of professionals or to particular grades or bands.

e. Under the MCA, any health or social care worker may assess capacity and make decisions for someone who lacks capacity in their “best interests”. However, depending on the decision to be made, a qualified professional may be required to complete the assessment and on occasions a joint assessment may be required. Formal decisions will require the completion of an assessment form and record of a best interests decision. Those staff who have responsibility for these types of decisions as part of their role will need to be familiar with these forms.

f. The policy and guidance also set out to:

- Ensure the analysis of capacity begins with identifying any inability to *understand, retain, use, and weigh* information relevant to a decision, and evidence of any *impairment or disturbance* is addressed subsequently.
- Make explicit reference to the need to demonstrate the 'causal nexus'.
- Clarify the 'unable to communicate' grounds.
- Separate out the statements on making the judgement and concluding the assessment.
- Clarify language.

3. Scope of Policy

a. Those who are involved in providing care, support or treatment to a person who lacks capacity are legally obliged to implement the MCA and to have regard to the Code of Practice. Worcestershire County Council (WCC), Worcestershire Health & Care NHS Trust and Worcestershire Acute Hospitals NHS Trust expect that the practice of their employees will be in keeping with the Act and the guidance contained in the Code of Practice. This policy applies to all staff involved in health and social care, including temporary employees, locums, agency staff, contractors and visiting clinicians.

b. Any deviation from the Code of Practice and the reasons for this must be clearly recorded.

c. Knowledge of this policy and procedure alone will not be sufficient to ensure practice is defensible, and staff will have to be familiar with the contents of the MCA and its associated Code of Practice and related guidance.

d. This policy is for people deemed as adults of the age of 16 and above.

4. Definitions

a. **Advance Decision to Refuse Treatment (ADRT)** – a decision to refuse specific treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when the person lacks capacity to consent to or refuse the specified treatment.

NB specific rules apply to advance decisions to refuse life sustaining treatment. For further information see local policies for Advanced Decisions.

b. **Best Interests** – any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out what is in a person's best interests such as the person's views, wishes, lifestyle, culture, and beliefs. Any best interest decision made should be the least restrictive.

c. **Capacity** – the ability to make a decision regarding a particular matter at the time the decision needs to be made.

d. **Children** – the code of practice refers to children as being people aged below 16. This differs from the Children Act 1989 and the law more generally where the term 'child' is used to refer to people aged under 18.

e. **Court of Protection visitors** – are appointed by the Court to investigate with the Local Authority suspected abuse or to check on the welfare of a person who lacks capacity.

f. **Decision maker** – under the Act many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code, as the decision maker. It is the decision maker's responsibility to determine what would be in the best interests of the person who lacks capacity.

g. **Deputy** – The Court of Protection will appoint and direct Deputies to make ongoing specific property/financial affairs and/or health and welfare decisions in the 'best interests' of people after they become incapacitated. Deputies will be CRB checked, and will be supervised by the Public Guardian, including existing Receivers. The Court defines their powers and limitations. They are required to submit reports and to keep records. They have a right to be consulted as appropriate, and their 'best interest' view should be agreed or the matter will be brought to the Court.

Deputies cannot:

- Prohibit contact with named persons.
- Direct healthcare providers to allow another to take over.
- Settle property or execute wills.
- Override a decision within the scope of a LPA.
- Refuse consent to a life sustaining intervention.

i. **Deprivation of Liberty Safeguards (DoLS)** – These were introduced in 2007 and are an additional safeguard to those contained within the original Mental Capacity Act 2005. Deprivation of a persons' liberty can occur where, for their own safety and in their best interests, a person needs to be accommodated under a care regime that has the effect of removing their liberty. That person must lack the capacity to consent to be subject to a DoLS.

j. **Donee** – is an individual named by a person when they have capacity; to represent them at times when they lack capacity.

k. **Donor** – an individual who at the time has capacity to delegate decisions regarding their health and welfare or property and finance to a nominated person known as a Lasting Power of Attorney

l. **Enduring Power of Attorney (EPA)** – a power of attorney created under the Enduring Powers of Attorney Act (1985) appointing an attorney to deal with the donor's property and Financial affairs. Existing EPA's will continue to operate under Schedule 4 of the Act, which replaces the EPA Act 1985.

m. **Independent Mental Capacity Advocate (IMCA)** – IMCAs are instructed by designated decision makers as per the IMCA Engagement Protocol for unbefriended people where there are serious medical treatment and accommodation move decisions. They can request information, copies of records, a meeting, and a second opinion; can challenge decisions and seek a Court decision. They can also work alongside an existing advocate.

n. **Lasting Power of Attorney (LPA)** – A Power of Attorney created under the Act who is over the age of 18, registered with the Public Guardian, who is nominated to manage finances/property and / or to manage health / welfare decisions when an individual loses capacity. Their powers may enable full decision-making, including life-sustaining decisions, or they may be limited to specific decisions and circumstances by an adult when they have capacity. Those actions under LPAs must abide by Code of Practice

standards, court directions and provide any requested court reports. Relevant professionals must be consulted when necessary.

o. **MCA 1** – form to record assessment of capacity. Available from WSAB website.

p. **MCA 2** – form to record rational for Best Interest Decision. Available from WSAB website.

q. **Medical records** – electronic and paper files relevant to the person concerned and to the current decision.

r. **Office of the Public Guardian (OPG)** – The Public Guardian is an officer established under Section 57 of the Act. The Public Guardian will be supported by the Office of Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, check on what the attorneys are doing, and investigate any complaints about attorneys or deputies.

s. **Receivers** – An individual appointed by the - Court of Protection prior to October 2005 to manage the property and affairs of a person lacking capacity to manage them. Existing receivers continue as deputies with legal authority to deal with the person's property and affairs.

t. **Restraint** – the use or threat of force to help do an act which the person resists, or the restriction of someone's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

u. **Serious health/medical treatment** – includes invasive assessment and treatment; and involves providing new treatment or withholding or stopping treatment that has already started. Some examples of medical treatments that might be considered serious include:

- Chemotherapy and surgery for cancer.
- Electro-convulsive therapy.
- Therapeutic sterilisation.
- Major surgery (such as open-heart or brain/ neurosurgery).
- Major amputations (e.g. loss of arm or leg).
- Treatments that will result in permanent loss of sight or hearing.
- Withholding or stopping artificial nutrition and hydration.
- A Do Not Resuscitate decision or similar
- Termination of pregnancy

These are illustrative examples only and whether these or other procedures are considered serious medical treatment in any given case will depend on the circumstances and the consequences for the person.

t. **Unbefriended** – the person has no friend, family, nominee, or legal representative in effective contact with them, or who is willing or appropriate to represent their best interests.

u. **Young People** – the Act refers to young people as being aged 16-17 years.

5. Responsibilities and Duties

a. **Employers / Managers** – are responsible for ensuring the requirements of this policy are implemented within their area of responsibility. Responsibilities include safer recruitment practices; supporting staff and arranging appropriate development/training for roles; auditing practice; seeking other professional involvement; risk management; complaints and dispute resolution.

- To ensure staff are aware of and abide by the MCA and the Code of Practice.
- To ensure staff are made aware of legal responsibilities.
- To ensure staff complete correct documentation.
- To ensure staff are aware of referral procedures.
- To ensure staff can access appropriate training.

b. Types of decision makers:

i. **All staff** are responsible for applying the requirements of this procedure in the circumstances faced in their role, and in accordance with training attended and risk assessments. A duty of care requires that reasonable measures are taken to prevent harm in an appropriate manner. When caring for someone who lacks capacity to appreciate danger or the consequences of their actions, the employee must make best interest, least restrictive decisions to safeguard the person and others. Employees are responsible for recording the action within the medical record and notifying the manager on duty of any best interest decision made or restrictive intervention used.

ii. **Doctors, Psychiatrists, Nurses, Therapists, Psychologists and Specialist Nurses** who carry out invasive assessment and physical treatment, psychiatric treatment, and Continuing Health Care assessments / reviews are all decision makers, who must seek consent / determine capacity and 'best interests'.

iii. **Doctors and Psychiatrists** also determine the validity of an advance decision and arrange second opinions on request. Certain decisions require Court directions, and formal / certifying mental capacity assessments by specialists, e.g. Doctors, Psychiatrists, Psychologists, and counter signatories. These staff can be part of a multi-disciplinary team designated by their organisation to make best interest decisions.

iv. **The Court of Protection** is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court of Protection is established under Section 45 of the Act.

v. **The Office of the Public Guardian** supervises Deputies and LPAs by reports, and with the OPG arranges registration of LPAs, investigates abuse with Local Authorities, and provides public advice.

vi. **Court of Protection Visitor** provides written reports after welfare visits/investigations of abuse with the Local Authority.

6. Definition of Mental Capacity

Having mental capacity means that a person can make their own decisions. If a person is deemed to lack capacity, then the person is unable to make a particular decision.

a. The principles of the MCA

There are five key principles which emphasise the fundamental concepts of the MCA.

i. Every adult has the right to make his or her own decisions and assumed to have capacity unless it is proved otherwise.

ii. People must be supported as much as possible to make their own decisions before anyone concludes that they cannot make their own decision.

iii. People have the right to make what others might regard as unwise or eccentric decisions.

iv. Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

v. Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms.

b. Helping people to make decisions for themselves

i. When a person needs to make a decision, it must be assumed that the person has capacity to make the decision in question (Principle 1). Every effort should be made to encourage and support the person to make the decision themselves (Principle 2) and consideration of a number of factors to assist in that decision making.

ii. These could include:

- Does the person have all the relevant information needed to make the decision? If there is a choice, has information been given on the alternatives?
- Could the information be explained or presented in a way that is easier for the person to understand? For example, a person with a learning disability might find it easier to communicate using pictures, photographs, videos, tapes, sign language or an interpreter if non-English speaking.
- Are there particular times of the day when a person's understanding is better or is there a particular place where they feel more at ease and able to make a decision?
- Can anyone else help or support the person to understand information or make a decision? For example, a relative, friend, or independent advocate

iii. It must be remembered that if a person makes a decision which is thought to be eccentric or unwise, this does not necessarily mean that the person lacks capacity to make the decision.

iv. When there is reason to believe that a person lacks capacity to make a decision the following points must be considered:

- Has everything been done to help and support the person to make a decision?
- Does this decision need to be made without delay? If not, is it possible to wait until the person does have the capacity to make the decision for him or herself?

v. If the person's ability to make a decision still seems questionable then an assessment of capacity needs to be made. Sometimes, this will be a formal assessment, but not always. See **Appendix 1** for a guide as to when to assess capacity.

c. Types of decisions and assessments

i. Under the MCA, capacity assessments are the responsibility of the person who is responsible for the decision. This person is known as the "Decision Maker."

ii. In informal situations, the decision maker may be an informal carer or family members who make decision on behalf of a cared-for person. The legal authority of these people to make more serious decisions is limited to Attorneys or Deputies.

d. Informal Decisions

i. These may be what to wear, eat, or how to spend time. These are not significant decisions and should not need in-depth analysis each time an act is done on behalf of an adult who lacks capacity. This said, they are important decisions and not understanding and respecting the person's preferences can result in a negative impact for the person. Some of these decisions are expressions of identity and if these are undermined or disregarded, it can have a significant impact on the person's wellbeing and independence.

ii. It is a requirement that within each person's care plan it will be clearly identified how they wish to live their lives, including where appropriate comprehensive details of support that may be required for this to be achieved. The MCA provides for each decision to be unique in its nature. The absence of functional capacity to make major decisions does not therefore exclude the person from routine daily life choices and decisions.

iii. All individuals supporting the person, must, regardless of a person's mental capacity seek consent to complete the support they offer on each and every occasion.

iv. Where a person who lacks capacity is unable to provide consent routinely for whatever reason then consideration must be given to developing a Best Interest decision. The development of a Best Interest Decision should wherever possible include those with a wider interest in the person's wellbeing such as next of kin and/or other family members together with consulting health professionals. The Best Interest Decision maker by adopting this approach can ensure all concerned feel confident in the extent of care and support to be provided.

v. Staff need to have a support plan or guidance in place to cater for when someone resists or refuses a care act or medication. In the first instance, staff should not be expected to force an act of care or medication on someone, and they should refer the situation back to senior staff.

vi. When a person repeatedly refuses an act of care, or refuses a significant act, staff should consider the person's capacity for this decision, and take formal steps to assess and if necessary, determine what is in their best interests, in order to inform how staff respond.

e. Formal decisions

i. These are where the action may have significant consequences beyond the day to day; they must be recorded using form MCA1**.** This is where:

- The decision has a long term or significant consequence.
- The decision relates to a situation of substantial or critical risk.
- There is likely to be disagreement or challenge in the decision.

ii. The nature of these decisions means that it is likely to be qualified staff – Social

Workers, Doctors, Senior Nurses, Senior Care staff – that make them and document them.

f. How to approach the assessment of mental capacity

i. An assessment of mental capacity for a specific decision begins with an analysis of whether the person is able to make the decision. That is, whether they can:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision (where a decision can be made)

This must involve giving all practicable support to help the person make the decision (or communicate their decision) themselves.

ii. If it is then evident that the person cannot do so, it will be necessary to consider whether that inability is because of an *impairment or disturbance in the functioning of the mind or brain*. This can be permanent or temporary, and can include coma, the effect of drugs or alcohol, delirium, mental disorder, dementia, acquired brain injury, etc.

iii. The MCA specifically states that the inability to make a decision must be *because of* the impairment or disturbance identified. Therefore, linking the two aspects is essential in any formal assessment. This has become known as the *causal nexus* and the importance of specifically addressing it has been clearly stated in subsequent case law.

iv. Every effort should be made to find ways of communicating with the person being assessed and these efforts recorded. Most people will be able to communicate to some extent, and it will only be in exceptional situations that it would be appropriate to find them unable to make a decision on these grounds alone. It is intended to apply to people who have rare conditions such as locked-in syndrome – cognitively able but unable to communicate in any way.

v. A judgement that a person lacks capacity for a decision is made on the balance of probabilities: that it is more likely than not that the person lacks capacity.

vi. Where there is potential for recovery and regaining capacity, this should be stated on the decisions document.

vii. If the inability to make a decision is not due to any impairment or disturbance in the mind or brain but thought to be due to some other factor such as external influence or coercion of others, the MCA cannot be used. However, a decision may need to be made for them in Court under the inherent jurisdiction and legal advice should be sought.

g. Assessing "Decision Specific" Capacity

i. The MCA makes clear that any assessment of a person's capacity must be 'decision-specific'.

ii. This means that assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions.

iii. If someone cannot make a complex decision that does not mean that they cannot make simple decisions.

iv. It is good practice to ensure that relevant friends and family and other professionals are informed of an assessment of capacity.

h. Making a decision in someone's "Best Interests"

i. If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests (Principle 4).

ii. You cannot make a decision in someone's best interests if there has not been an assessment of their capacity beforehand finding that the person is unable to make the decision. The form MCA2 should be used to record the best interests decision making process.

iii. The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day to day care, or a professional such as a doctor, nurse, therapist or social worker.

iv. The Code of Practice sets out a checklist of key factors which you must consider when working out what is in the best interests of a person who lacks capacity. This list is not exhaustive and you should refer to the Code of Practice for more details.

v. A decision cannot be made that someone lacks capacity based upon their age, appearance, condition or behaviour alone. The decision maker must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.

vi. The decision-maker must consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision or act wait until then?

vii. The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.

viii. If the decision concerns the provision or withdrawal of life-sustaining treatment the decision-maker must not be motivated by a desire to bring about the person's death.

ix. Also, refer to part 8 of this policy concerning statutory duties to involve an IMCA.

i. Considerations for the decision-maker:

i. The person's past and present wishes and feelings (in particular if they have been written down).

ii. Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors.

iii. As far as possible the decision-maker must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

- Anyone previously named by the person lacking capacity as someone to be consulted.
- Carers, close relatives or close friends or anyone else interested in the person's welfare.
- Any Attorney appointed under a Lasting Power of Attorney, under the appropriate category.

- Any Deputy appointed by the Court of Protection to make decisions for the person.

iv. The decision-maker must take the above steps, amongst others and weigh up the above factors to determine what decision or course of action is in the person's best interests.

v. Family and friends will not always agree about what is in the best interests of an individual. The decision maker is required to demonstrate clearly in documentation that a decision has been made based on all available evidence and taken into account all the conflicting views.

vi. If there are difficulties consulting and the decision must be made urgently, do not delay, but review the decision when you have established the views of others.

j. **Disputes about the person's best interests**:

i. In the case of a dispute the following points should be used to determine a person's best interests:

- Hold a formal or informal case conference.
- Get a second opinion.
- Involvement of an advocate independent of all parties involved.
- Go to mediation.
- An application could be made to the Court of Protection.

k. Concluding and not making a decision:

In some situations the best interests process may begin but it becomes apparent that either: opportunities arise to further help the person make their own decision, a decision cannot be made yet as further information is needed, or that the decision itself is not needed at that time.

7. Children and Young People

See section 12 of the Mental Capacity Act 2005 code of practice for full guidance. It is important that everyone is clear which safeguarding procedures should be implemented in situations involving 16-17 year olds.

a. Children – aged under 16 years

The Act does not generally apply to people under the age of 16. There are 2 exceptions:

- The Court of Protection can make decisions about a child's property or finances if the child lacks capacity to make such decisions and is still likely to lack capacity to make financial decisions when they reach the age of 18.
- Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

b. Young People – aged 16-17 years

Most of the act applies to young people aged 16-17 years of age. There may be an overlap with The Children Act 1989. For the Mental Capacity Act 2005 to apply to a young person they must lack capacity to make specific decisions as set out above. There are 3 exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over.

c. Care and treatment of young people aged 16 or 17

The Family Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. This also applies to any associated procedure i.e. investigations, anaesthesia or nursing care. As with adults, decision-makers should assess the young person's capacity to consent to the proposed treatment or care. If the young person lacks capacity to consent because of an impairment or disturbance of the brain, then the MCA will apply in the same way as it does who are 18 and over. If they lack capacity for any other reason for example because they are overwhelmed by the implications of the decision, the act will not apply to them and the legality of any treatment should be assessed under common law principles. The act does not apply to some rare types of procedure for example organ donation or research. In these cases anyone under 18 is presumed to lack legal capacity, subject to the test of 'Gillick competence'.

8. Independent Mental Capacity Advocate (IMCA) Service

- In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare, or from a Deputy or an Attorney appointed under a Lasting Power of Attorney.
- However, some people who lack capacity may have no one to support them (other than paid staff) to make major, potentially life-changing decisions, so Independent Mental Capacity Advocates (IMCA) must be appointed to represent and support them.
- An IMCA will not be the decision-maker, but the decision-maker will have a duty to take into account the information given by the IMCA.
    - NB It should be noted that even if an IMCA is required this should not prevent emergency medical decisions and care being given in life threatening situations.

a. When it is necessary to involve an IMCA:

- the decision is about a serious medical treatment.
    - Serious medical treatment is defined in the MCA as treatment which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where:
        - if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved
        - a decision between a choice of treatments is finely balanced, or
        - what is proposed is likely to have serious consequences for the patient.
- it is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home.
- a long-term move (8 weeks or more) to different accommodation is being considered, for example, to a different hospital or care home.
- The person is made subject to DoLS (see separate local policies for DoLS).

- Care reviews.
- Adult protection cases: whether or not family, friends or others are involved.

In England, Local Authorities and the NHS have been given powers to extend the IMCA service to specific situations if they are satisfied that an IMCA would provide particular benefit, these are care reviews about accommodation and decisions about adult protection issues.

b. Duties of an IMCA:

- support the person who lacks capacity and represent their views and interests to the decision-maker.
- obtain and evaluate information – an IMCA can talk to the person in private and examine, and where appropriate, take copies of health and social care records such as clinical records, care plans or social care assessment documents.
- as far as possible, ascertain the person's wishes and feelings, beliefs and values.
- ascertain alternative courses of action.
- obtain a further medical opinion, if necessary.
- prepare a report for the person who instructed them. If an IMCA disagrees with the decision made, they can also challenge the decision-maker.

c. Making a referral to the IMCA Service

i. The decision that a person will require an IMCA should be made at the earliest point possible following admission/engagement with service. When the decision has been made that an IMCA is required then the referral should be made.

ii. The IMCA service in Worcestershire is at the time of approval of this policy provided by Onside Advocacy.

To make a referral –. complete the referral form here

Email the referral to imca@onside-advocacy.org.uk.)

General enquiries 01905 27525.

Postal address

Onside Independent Advocacy
Williamson House
14 Charles Street
Worcester
WR1 2AQ

iii. Once an IMCA referral has been made and accepted no further action can be taken until the IMCA report has been received (except in an emergency) and taken into account when making a best interest, least restrictive decision. The IMCA service should be notified of the decision that is taken.

9. Providing Care or Treatment for People who have Planned Ahead

a. Advance Decisions to Refuse Treatment (ADRT)

i. Sometimes people have clear views about what types of treatment they do not want to have and would not consent to. An advance decision allows them to express these views clearly before they lose capacity. The MCA puts advance

decisions, sometimes called advance directives or 'living wills' on a statutory footing. It also explains what is required in law for an advance decision to be valid and applicable and introduces new safeguards.

ii. An advance decision is where a person aged 18 or over may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if the refusal may result in the person's death and if it is valid and applicable it must be followed.

NB: With the exception of decisions relating to life-sustaining treatment, where advance decisions must be signed and witnessed, an advance decision does not need to be in writing.

iii. If a person has made an advance decision refusing a particular medical treatment, and that advance decision is valid and applicable, then the refusal has the same force as when a person with capacity refuses treatment.

iv. Requirements for Advance Decisions

The MCA introduces a number of rules people must follow when making an advance decision. If you are making a decision about treatment for someone who is unable to consent to it, you must be satisfied that the advance decision exists, is valid and applicable to the particular treatment in question. The following list gives a very brief summary of some of the main requirements for advance decisions:

- It must be valid. The person must not have withdrawn it or overridden it by making an LPA that relates to the treatment in the advance decision or acted in a way that is clearly inconsistent with the advance decision.
- It must be applicable to the treatment in question. It should clearly refer to the treatment in question (detailed medical terms do not have to be used) and it should explain which circumstances the refusal refers to.
- Where people are detained under the Mental Health Act 1983, their mental disorder can be treated for mental disorder without their consent.
- People cannot make an advance decision to ask for medical treatment – they can only say what types of treatment they would refuse,
- People cannot make an advance decision to ask for their life to be ended.

v. If you are satisfied that the decision is valid and applicable, then you will have to abide by that decision.

b. Advance Decisions that refuse life-sustaining Treatment

i. The MCA sets out additional formalities for advance decisions that refuse life-sustaining treatment. An advance decision to refuse life-sustaining treatment must fulfil the following additional requirements:

- It must be in writing, which includes being written on the person's behalf or recorded in their medical notes.
- It must be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are unable to sign it for themselves. This must also be witnessed.

- It must be verified by a specific statement made by the maker, either included in the document or a separate statement, which says that the advance decision is to apply to the specified treatment even if life is at risk. If there is a separate statement this must also be signed and witnessed.

ii. Providing care or treatment for people who have made advance decisions is a complex area and it is advisable to refer to Chapter 9 of the Code of Practice for more detailed guidance.

c. Liability of Health Care Professionals

i. Staff will not incur liability for providing treatment in a person's best interests if they are satisfied that a valid and applicable advance decision exists. If an advance decision exists which is valid and applicable, then not to abide by it could lead to a legal claim for damages or a criminal prosecution for assault.

ii. If staff reasonably believes that there is a valid and applicable advance decision, they will not be held liable for the consequences of abiding by it and not providing treatment. It should be clearly recorded how conclusions were arrived at.

d. Disputes and Disagreements about Advance Decisions

i. Where there is a disagreement about whether or not an advance decision is valid and applicable the Code of Practice should be consulted for more detailed guidance or advice sought from the organisation's MCA Lead.

ii. If there is a dispute or difficulty, then mediation should be considered or the matter could be referred to the Court of Protection by staff or a relative, carer or a close friend of the person.

e. Dealing with Advance Decisions that were made before October 2007

i. People could already make advance decisions sometimes known as a 'living will'. If any of the people you provide care or treatment for have already got an advance decision, you should check that it meets the rules that the MCA sets out to ensure that it is still valid and applicable. If the person has already lost capacity, then the advance decision may still be binding.

f. Statements of Wishes and Feelings and Beliefs and Values

i. Sometimes people will want to be able to write down or tell people about their wishes and preferences about future treatment and care and explain their feelings or values that govern how they make decisions. These statements can be about anything, including personal preferences such as having a shower rather than a bath, or wanting to sleep with the light on.

ii. When assessing what treatment or care is in a person's best interests, these statements must be taken into account. Such statements can request certain types of treatment, which must be considered carefully, in particular if they have been written down. However the final decision must always be based on assessment of what is in the person's best interests and clinical professional judgement of what is clinically necessary or appropriate. If this is different to what they have said in their statement of wishes and feelings a record of this should be documented and staff be prepared to justify their decision if challenged.

NB: these are not legally binding, but it is good practice to take them into account.

10. Powers of Attorney

The MCA has far reaching effects for people who work in health because it extends the ways in which people using services can plan ahead for the time when they may lack capacity. These are Lasting Powers of Attorney (LPA's), advance decisions to refuse treatment, and written statements of wishes.

If you are providing care or treatment for someone who lacks capacity these may be very helpful in deciding what to do. If you are working with people who have capacity, or who have fluctuating capacity, it may be helpful for you to explain to them these ways of planning ahead for a time when they may lack capacity.

a. Lasting Powers of Attorney (LPAs)

i. The MCA introduces a new form of Power of Attorney which will allow people over the age of 18 to formally appoint someone to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. They must be *registered by the Office of the Public Guardian to be valid. Each page will be stamped accordingly.*

ii. *The person* making an LPA will be called the **Donor.** The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person appointed will be known as a **Donee.**

iii. The LPA will give the attorney authority to make decisions on behalf of the donor and the attorney will have a duty to act or make decisions in the best interests of the person who has made the LPA.

b. There are two different types of LPA:

- A health and welfare LPA is for decisions about both health and personal welfare.
- A property and financial affairs LPA is for decision about financial matters.

c. Important Facts about LPAs and EPAs

i. The introduction of the LPA for property and financial affairs means that no more Enduring Powers of Attorney (EPA) could be made after October 2007. The MCA makes transitional provisions for existing EPAs to continue - whether they are registered or not. This means that pre-existing EPAs can continue to be used and they can continue to be registered after 2007.

ii. When a person makes an LPA, they must have the capacity to understand the importance of the document and the power they are giving to another person.

iii. Before an LPA can be used it must be registered with the **Office of the Public Guardian**. This is vital, without registration an LPA cannot be used at all.

iv. A health and welfare attorney will have no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision for him or herself.

v. If the person in your care lacks capacity and has created a health and welfare LPA, the attorney will be the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the attorney's authority the attorney will have the authority to make health and welfare decisions and refuse treatment (**except life-sustaining treatment)** on the donor's behalf. The attorney must make these decisions in the best interests of the person lacking capacity and if there is a dispute that cannot be resolved, e.g. between the attorney and a doctor,

it may have to be referred to the **Court of Protection.**

vi. If the decision is about life-sustaining treatment, the attorney will only have the authority to make the decision if the LPA specifies this.

vii. If you are directly involved in the care or treatment of a person who lacks capacity, you should not agree to act as their attorney other than in exceptional circumstances, for instance, if you are the only close relative of the person.

viii. The existence of a valid LPA can be checked by completing form OPG100 available from the Office of the Public Guardian internet page. Address at time of policy approval https://www.gov.uk/government/news/new-form-and-guidance-to-help-you-search-opgs-registers

11. Confidentiality and Record Keeping

a. An assessment of capacity may require the sharing of information amongst health and social care workers. If a person lacks capacity to consent to disclosure, then a decision needs to be made as to whether it would in their best interests to disclose the information. Only as much information as necessary should be divulged.

b. Where an attorney under a health and welfare LPA has been appointed, they will determine if information can be disclosed, and they should be consulted before sharing any information. Where it is not possible to consult, for example, because urgent treatment is necessary, staff must act in the person's best interests and advise the attorney of any action taken as soon as practicable.

12. Powers of the Court of Protection and Deputies

a. The Court of Protection

i. This specialist Court has jurisdiction relating to the whole of the Act. It deals with decisions concerning both the property and financial affairs and the health and welfare of people who lack capacity. It is particularly important in resolving complex or disputed cases, for example, about whether someone lacks capacity or what is in their best interests. In specific situations, the Court of Protection is also able to consider cases relating to children who are under 16, for example when longer term decisions need to be made about their financial affairs.

ii. The Court of Protection has the power to:

- make declarations about whether or not a person has capacity to make a particular decision.
- make decisions on serious issues about healthcare and treatment.
- make decisions about the property and financial affairs of a person who lacks capacity.
- appoint Deputies to have ongoing authority to make decisions.
- make decisions in relation to Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs).
- The Court is able to appoint a deputy if necessary, for example because a person has an ongoing lack of capacity. The power given to a deputy will vary from case to case.

NB: Paid health and social care professionals will not usually be appointed as Deputies because of the possible conflict of interests.

b. The Public Guardian

i. The role of the Public Guardian is intended to protect people who lack capacity from abuse. The Public Guardian will be supported by the Office of the Public Guardian (OPG). Some of the tasks of the Public Guardian will include:

- maintaining a register of LPAs and EPAs.
- maintaining a register of orders appointing Deputies.
- supervising deputies appointed by the Court.
- directing Court of Protection Visitors to visit people lacking capacity.
- receiving reports from Attorneys acting under LPAs and from Deputies.
- providing reports to the court as requested.
- dealing with representations (including complaints) about the way in which Attorneys exercise their powers.
- Providing general information about the MCA.

13. Exclusions to the Act (Appendix 2)

a. The Act excludes a number of decisions that can be made on behalf of a person who lacks capacity (s27-s29, s62) e.g. nobody is allowed to consent to a marriage or a civil partnership on behalf of a person who lacks capacity.

14. Safeguarding

a. The presumption is that adults have the mental capacity to make informed decisions about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in Safeguarding Adults. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability:

- to understand the implications of their situation.
- to take action themselves to prevent abuse.
- to participate to the fullest extent possible in decision-making about interventions.

b. The MCA 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act.

15. Audit and Review

a. Each signatory will undertake audits of the use of the Mental Capacity Act as deemed necessary within each organisation, or at the request of Worcestershire Safeguarding Adults Board through its subgroups.

16. Training

a. Each signatory organisation will ensure that appropriate training is made available to staff so that they are skilled and competent in the use of the Mental Capacity Act 2005.

17. Links to other legislation

a. The MCA will apply in conjunction with other laws relevant to or affecting the property and affairs, care or treatment of people who may lack capacity in relation to specific matters. People who work in health and social care should also be aware of their obligations under other laws including (but not limited to):

- Care Standards Act 2000
- General Data Protection Regulation and Data Protection Act 2018
- Disability Discrimination Act 1995
- Equality Act 2010
- Human Rights Act 1998
- Mental Health Act 1983 (amended 2007)
- Care Act 2014Human Tissues Act 2004
- Human Fertilisation and Embryology Act 1990
- Health and Social Care Act 2008

18. Monitoring and Compliance

a. The signatories to this policy are members of the Worcestershire Safeguarding Adults Board.

b. Training attendance statistics will be reported to the Performance and Quality Assurance subgroup.

19. Policy Review

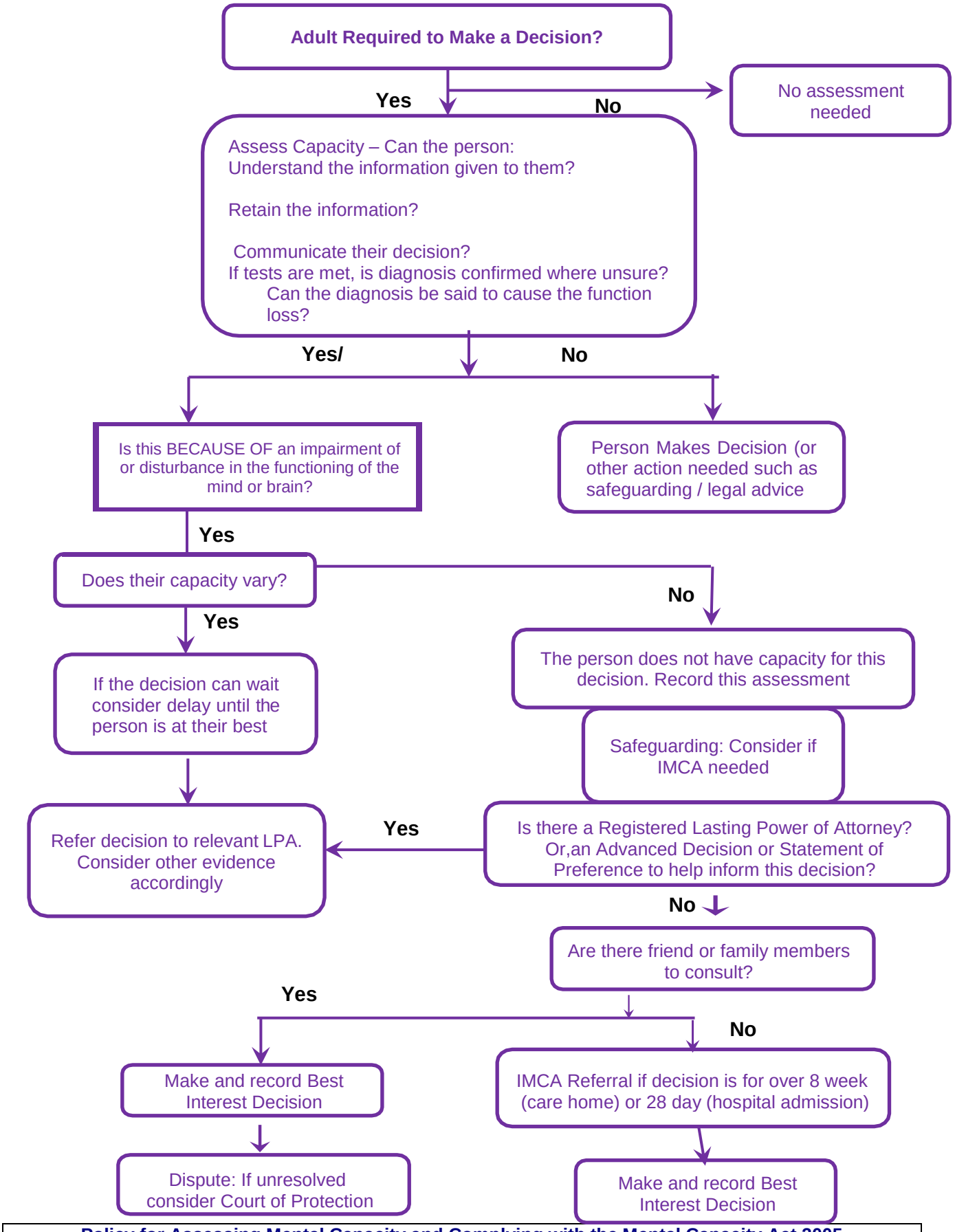
a. This policy will be reviewed in three years' time. Earlier review may be required in response to organisational change or relevant changes in legislation or guidance.

20. References

Mental Capacity Act 2005 – www.legislation.gov.uk/ukpga/**2005**/9/contents

Code of Practice February 2007 – https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Appendix 1: When to Assess Capacity (People over 16)



Appendix 2 – Decisions that are excluded under the Mental Capacity Act 2005

1. Decisions concerning family relationships (Section 27)

Decisions that must not be made on someone else's behalf are:

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

2. Mental Health Act matters (Section 28)

Where a person who lacks capacity to consent is currently detained and being treated under Part IV of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- give the person treatment for mental disorder.
- consent to the person being given treatment for mental disorder.

Further guidance is given in chapter 13 of the Mental Health Act 1983 (amended 2007) Code of Practice.

3. Voting rights (Section 29)

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

4. Unlawful killing or assisting suicide (Section 62)

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

5. Arranging legal representation

If you think a person who lacks capacity needs legal representation, seek advice from your legal department.

Background

1.1 Equality requirements

There are no equality requirements.

1.2 Financial risk assessment

There are no financial risk implications.

EQUALITY IMPACT ASSESSMENT

To be completed by the Treatment pathway owner and submitted to the appropriate committee for consideration and approval.

		Yes/No
1.	Does the treatment pathway affect one group less or more favourably than another on the basis of:	No
	Race	No
	Ethnic origins (including gypsies and travellers)	No
	Nationality	No
	Gender	No
	Culture	No
	Religion or belief	No
	Sexual Orientation	No
	Age	No
2.	Is there any evidence that some groups are affected differently?	No
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No
4.	Is the impact of the policy/guidance likely to be negative? If so can the impact be avoided?	No
5.	What alternatives are there to achieving the policy/guidance without the impact?	No
6.	Can we reduce the impact by taking different action?	No
7.	Other comments	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

FINANCIAL IMPACT STATEMENT

To be completed by the Treatment pathway owner and submitted to the appropriate committee for consideration and approval.

		Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
6.	Other comments	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval