NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

NHS Harrogate and Rural District Clinical Commissioning Group

NHS Scarborough and Ryedale Clinical Commissioning Group

NHS Vale of York Clinical Commissioning Group

Item 9.1

Title:	**MENTAL CAPACITY ACT (2005) POLICY**
Reference No:	
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Distribution:	All staff in line with the CCG through line management structure
Compliance:	Mandatory for all permanent & temporary employees, contractors & sub-contractors of CCGs
Equality & Diversity Statement:	This policy has been subject to a full Equality Impact Assessment

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CHANGE RECORD			
DATE	AUTHOR	NATURE OF CHANGE	VERSION No
14.02.13	Janis Bottomley & Chris Brace	Amendments to contextualise policy in respect of CCGs.	0.01

1. **Contents**

2. Introduction

2.1 The Mental Capacity Act (MCA) 2005 (the "Act") provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It sets out a framework for assessing whether an individual has the necessary capacity to make a particular decision, and it makes provision for people who have capacity to plan ahead for a time when they may lack capacity and gives a power to staff (and others) working with people who lack the capacity to consent, to make decisions in the individual's best interest.

2.2 The scope of the legislation is vast; the Act may be engaged in decisions relating to personal welfare including social care, health care and treatment as well as decisions concerning financial affairs.

2.2.1 This policy includes the procedural requirements and the expectations of Hambleton, Richmondshire and Whitby Clinical Commissioning Group, Harrogate and Rural District Clinical Commissioning Group, Scarborough and Ryedale Clinical Commissioning Group and Vale of York Clinical Commissioning Group (CCGs) in the application of the Act in all care settings for which CCGs are accountable.

2.2.2 The policy is a component of the CCGs' strategy for securing compliance with the Act and ensuring that employees have regard to the guidance.

2.2.3 The policy requires that Managers ensure that staff for whom they are responsible attend the statutory training.

2.3 This policy reinforces the duty to exhaust all practicable steps in helping the individual make their own decision, including considering postponing the decision if it does not have to be taken immediately and the individual might regain capacity, before they are treated as lacking capacity.

2.4 Section 1 of the Act sets out five principles that must be followed by everyone using the Act in every action and decision they take on behalf of a person who may lack capacity. Staff must also have regard to the guidance given in the MCA Code of Practice.

2.4.1 Copies of the MCA Code of Practice have been distributed widely across the health and social care economy. Further copies can be downloaded from:
http://www.justice.gov.uk/downloads/guidance/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

2.5 This policy establishes procedural instructions for:

- the assessment of capacity;
- determining best interest;
- making decisions;

- instructing an Independent Mental Capacity Advocate (IMCA).

2.5.1 This policy requires Managers and Service Managers to follow the procedure for referral to the contracted IMCA service and the Guidance on Advance Statements and Advance Decisions to Refuse Treatment - Designed by Yorkshire people for Yorkshire People. (see link at Paragraph 23)

2.5.2 Chapter 9 MCA Code of Practice provides further guidance) (see link at Paragraph 23).

2.6 Contemporaneous record-keeping is essential. The judgement as to the extent of the record required will be influenced by the complexity and consequence of the decision being made.

3. Scope of the policy

3.1 The policy is mandatory for all permanent and temporary employees, contractors and sub contractors of CCGs and those staff within the North Yorkshire County Council and the City of York council who are included within the arrangements for collaborative care. The policy aims to provide direction and guidance to all staff who are involved in the assessment, care, treatment or support of people over 16 years of age who may lack the capacity to make some, or all, decisions for themselves. The policy must be read in conjunction with the MCA 2005 itself and the MCA Code of Practice. (Specific sections of the Code will be referenced within this policy where further clarification/guidance is necessary.)

3.2.1 Corporate, Departmental, multi-agency and Clinical Policies must continue to be reviewed in the light of the MCA 2005 and, where appropriate, cross referenced with this policy.

4. Policy statement

4.1 CCGs require its employees and those from whom it contracts services to be fully aware of their duties and responsibilities under the MCA 2005 and, to have regard to the guidance in the Code of Practice and, to follow the guidance and procedures set out in this policy. CCGs are committed to delivering care that is culturally and religiously sensitive to the needs of all patients. All sections of this policy aims to ensure that no present, or future patient, whether formal or informal, receives unfavourable treatment on the grounds of their race, sex, disability, colour, nationality, ethnic origin, religion, marital status, sexual orientation, or age. CCGs recognises the importance of following the protocol of various cultures and religions and staff must be sensitive to such issues in these circumstances.

5. The Mental Capacity Act 2005: the principles

5.1 The following principles, which appear on the face of the Act at Section 1, will guide staff in their decisions and actions and will act as benchmarks for decision makers.

1. A person must be assumed to have capacity unless it is established that he lacks capacity.

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

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests.

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

(Chapter 2 of the MCA Code of Practice expands on the application of the statutory principles.)

6. Assessing mental capacity - the ability to make a decision

6.1 Section 3 of the Mental Capacity Act 2005 sets out the test for determining whether a person lacks the capacity to make a particular decision at a particular time. Where there is cause to doubt that a patient has the capacity to make such a decision the professional directly concerned is required to undertake a two-stage capacity test. Professionals should never express an opinion without first conducting a proper examination and assessment of the person's capacity. Having established that the person lacks capacity the health professional must provide their evidence.

6.2 Assessment of capacity is a functional assessment. It must be specific to the decision to be made and not based on a general impression of capacity. The assessment should not be influenced by any factors other than those set out in section 3 of the Act and outlined in 6.4-6.7 below. The assessment should not be influenced by the consequences of the decision; nor should it be unduly influenced by the individual's diagnosis or status under the Mental Health Act.

For a decision to be valid, it must be freely made. If staff seeking a decision from a patient think that there may be undue pressure brought

to bear - perhaps from otherwise well meaning family or friends - steps should be taken to enable the patient to discuss the question alone.

Staff must always bear in mind that a person with capacity is entitled to make an unwise decision.

6.3 **Who should assess capacity?**

The role of assessor falls to the person who requires the decision, regardless of profession, grade or seniority. In some circumstances it may be appropriate to seek advice or a second opinion in order to inform the assessor's decision, however the final decision about a person's capacity must be made by the person who requires the decision, not the person providing the second opinion, who is there only to advise.

If a doctor or healthcare professional proposes treatment, they must assess the patient's capacity to consent. This can involve the multi-disciplinary team. But ultimately it is up to the professional responsible for the patient's treatment to make sure that capacity has been assessed.

6.4 **The test for capacity**

The Mental Capacity Act 2005 sets out the following two-stage test for capacity:

- Is there an impairment of or disturbance in the functioning of the person's mind or brain? If so,
- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

6.5 If the first part of the two-stage test is not applicable (i.e. there is no impairment or disturbance in mental functioning) then the person **cannot** be deemed to lack capacity to make the decision in question.

6.6 If there is impairment or disturbance in mental functioning then the second part of the test must be considered. A person is unable to make a decision for themselves if they are unable to:

a) understand the information relevant to the decision
and
b) retain the information (long enough to arrive at a decision)
and
c) use or weigh the information to arrive at a choice
and
d) communicate the decision

6.7 If the patient has difficulty communicating their decision all steps must be taken to aid communication and understanding.

6.8 **Mental Disorder and Capacity to Make Decisions**

It is likely that a person with mental disorder will meet the criterion of the first stage of the capacity test, i.e. have an impairment of, or disturbance in, the functioning of the mind or brain. However, it must not be assumed that the person therefore lacks the capacity to make decisions. The principle that 'a person must be assumed to have capacity unless it is established that he lacks capacity' applies equally to people with mental disorder.

It is undoubtedly the case that some mental disorders, by their nature or degree, have the potential to affect a person's ability to understand, retain, process or communicate information. Health professionals should therefore be mindful of the possibility that mental disorder may have compromised a patient's capacity to make specific decisions.

7. Documenting issues of capacity

7.1 Notwithstanding the presumption of capacity, health professionals should always give consideration to patients' capacity to make treatment or care related decisions. Furthermore, it is important that health professionals provide evidence in their notes of this consideration.

7.2 Where decisions are required about day-to-day care it is not necessary to assess capacity on a daily basis. A statement in the care plan addressing the issues of capacity and best interests, followed by regular review will suffice.

7.3 Where decisions are required for non-routine or more serious matters the assessment of capacity should be recorded in contemporaneous, appropriately detailed notes. Form MCA1 should be used for this purpose (see Appendix B) and regularly reviewed.

7.4 Where a health professional has no reason to consider the patient's capacity to make a specific decision (i.e. no evidence of mental disorder) they should for certain categories of patient record this in the notes. If, on the other hand, the health professional has reason to doubt the patient's capacity a formal assessment of capacity must be conducted and Form MCA1 completed and filed in the notes. The amount of detail required will depend on the nature of the decision and if additional detail is required it should be recorded in the notes and reference made on the form.

8. Best Interests

8.1 A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity, must be done, or made, in that person's best interests.

8.2 Careful consideration should be given as to who the 'Decision Maker' is. Where a **deputy** has been appointed by the **Court of Protection** to make welfare decisions such as the one in question then the deputy will be the decision maker. If there is no deputy but an **attorney (donee)** has been appointed under a **Lasting Power of Attorney** to make such decisions then the attorney will be the decision maker. In the absence of either a deputy or an attorney the decision maker will be the person requiring the decision.

8.3 The MCA 2005 clarifies the common law doctrines of necessity and best interest. It does not actually define the term **'best interests'**, however, Section 4 of the Act sets out a **checklist** of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist is only the starting point: in many cases, additional factors will need to be considered:

- Assess whether the person might regain capacity - if so, can the decision wait until then?

- Encourage participation - do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision;

- Identify all relevant circumstances - try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves;

- Find out the person's views - including: the person's past and present wishes, any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question, any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves;

- Consider any (relevant) written statement – (note that a valid and applicable advance decision to refuse treatment is legally binding and must be followed);

- Avoid discrimination – do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour;

- Does the decision concern life-sustaining treatment – if so, it should not be motivated in any way by a desire to bring about the person's death. Do not make assumptions about the person's quality of life;

- Consult others - if it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:

    - anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
    - anyone engaged in caring for the person (but take note of 8.4 below)
    - close relatives, friends or others who take an interest in the person's welfare
    - any **attorney** appointed under a **Lasting Power of Attorney** (see below)
    - For decisions about serious medical treatment or where the person should live, and where there is no-one from any of the above categories to consult, an Independent Mental Capacity Advocate (IMCA) must be consulted. (See Paragraph 17 of this policy).

- Avoid restricting the person's rights - consider if there are other options available that may be less restrictive of the person's rights.

8.4 **Best Interest Decision Meetings - Useful Guidance on Best Interest Meetings can be found on the intranet –** *http://nww.nyypct.nhs.uk/Directorates/Localities/MCA/BestInterests.htm*

9. Documenting Best Interests Decisions

The decision maker must provide clear evidence in the notes that they have considered and applied the best interests checklist. Form MCA2 should be used for this purpose (see Appendix C).

10. Protection For People Providing Care And Treatment

10.1 Section 5 of the MCA 2005 allows carers, healthcare and social care staff to carry out certain tasks and duties without fear of liability. Others who may occasionally be involved in the care or treatment of a person who lacks capacity to consent are ambulance staff, housing workers, police officers and volunteer workers**.** These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent. Chapter 6 of the MCA Code of Practice:-

- clarifies aspects of the common law principle of necessity, which enable decisions to be made for, but not on behalf of, people that lack capacity;
- re-emphasises the third principle (see Paragraph 5 of this policy) of empowerment and individual autonomy.

10.2 An act undertaken in connection with personal care might include:

- physical assistance such as washing, dressing, attending to personal hygiene, feeding, physically putting someone in a car or **ambulance;**
- shopping;
- arranging services for the person's care;
- and other practical tasks.

See paragraph 6.5 of the MCA Code of Practice for more detail (see link at Paragraph 23).

10.3 An act in connection with health care and treatment might be:

- Diagnostic examination and tests;
- Medical and dental treatment;
- Taking of blood or other samples;
- Nursing care, including wound dressings;
- Chiropody and physiotherapy.

Again, see paragraph 6.5 of the MCA Code of Practice for more detail, the above lists are illustrative and not exhaustive (see link at Paragraph 23).

10.4 Section 6 of the MCA places limitations on Section 5 protection from liability in two important areas:

(i) Limits to the use of restraint (note 11.2 below).
(ii) Does not permit acts that conflict with decisions made by a donee or court appointed deputy (note 12 below).

11. Deprivation of Liberty Safeguards & Restraint

11.1 This legislation introduces procedures for mentally incapable adults who may be subject to a deprivation of liberty. This is covered in a separate Deprivation of Liberty CCG policy.

11.2 Section 6(4) of the MCA states that a person is using restraint if they:-

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not

The restraint of a person who lacks capacity is permitted where:-

1. The person using it has cause to believe that it is necessary to prevent harm to the patient
   and
2. Its use is proportionate both to (a) the likelihood and (b) the seriousness of the harm
   and
3. The restraint is in the person's best interest (see above guidance on Determining Best Interest).

(Refer to MCA 2005 - Section 6) and paragraphs 6.40 to 6.48 in the MCA Code of Practice for further guidance – (see link at Paragraph 23)

11.3 However, where the level of restraint necessary to keep the patient safe amounts to a deprivation of liberty, the MCA 2005 Deprivation of Liberty Safeguards (DOLS) Code of Practice (see link at Paragraph 23) and the CCG Policy and Procedure should be adhered to. The MCA Code of Practice offers some guidance on what constitutes a deprivation of liberty; however the DOLS Safeguards are not prescriptive.

12. Lasting Powers of Attorney (LPA) and Donees

12.1 The MCA 2005 replaces the Enduring Power of Attorney (EPA) with the Lasting Power of Attorney (LPA), although it should be noted that EPAs made before 1 October 2007 remain valid.

12.2 There are as of October 2007 two distinct types of attorney:

1. financial and property;
2. personal welfare (including care and treatment)

They may be combined within one LPA.

12.3 A welfare power of attorney is a legal document that allows a capable adult (the donor) to give another person (the donee or attorney) authority to make decisions on their behalf, either generally or specifically, at a time when the donor no longer has capacity.

12.4 An attorney of a valid LPA has the same authority as a capable patient has when making a decision. A decision made by the donee must be treated as a decision made by the donor unless it is felt that there is evidence that the donee is not acting in the best interests of the donor, in which case legal advice should be sought.

12.5 A power of attorney is only valid when it is registered with the Public Guardian. A registered and valid LPA or EPA will be endorsed by virtue of an authorised stamp by the Office of the Public Guardian.

Clearly, staff will only acknowledge the decision-making power of an attorney where evidence of a valid LPA has been produced by the donee. Any person claiming to hold a lasting power of attorney must be asked to produce the validated document. Separate LPAs (involving different donees) may be created for welfare and financial matters. Welfare (including health) decisions can only be made by an attorney holding a valid Welfare Power of Attorney and the document will be clearly endorsed as such at the top of the form. Where practicable a copy of the endorsed Welfare Power of Attorney document should be placed in the patient's medical case notes.

13. <u>Court of Protection</u> (See Chapters 8 and 15, MCA Code of Practice [see link at Paragraph 23).

13.1 The Mental Capacity Act provides the Court of Protection with the power to make declarations about disputed and or complex circumstances relating to serious or major decisions. Day-to-day advice and guidance relating to matters of compliance with MCA and DOLS should be directed to the Independent Business Unit (IBU) hosted by Scarborough & Ryedale CCG. All matters relating to Court of Protection matters should be directed to the Legal Services Manager in the Commissioning Support Unit (CSU). Should proceedings be necessary, they will be conducted in the name of the relevant CCG.

13.2 Direct applications to the court for judgments may be made by:

1. The person who lacks or who is alleged to lack capacity;
2. Someone with parental responsibility for a person who has yet to reach age 18;
3. An attorney of a lasting power of attorney;
4. A Court of Protection appointed deputy;
5. A person named in an existing order of the court.

13.3 Staff or any other person wishing to make an application would need permission from the court to make an application to the court. This must be instigated by Legal Services in the CSU on behalf of the relevant CCG, and staff should contact them immediately. The court will weigh the benefits of the proposed application against any potential distress it may cause to the person lacking capacity.

13.4 Disagreements: It is therefore envisaged that disagreements between professionals over a person's capacity, or disputes involving the family of a patient over the proposed care or treatment, should be resolved locally as far as possible. Staff should therefore have exhausted all alternatives before seeking permission to apply for a court declaration. These may include mediation, either formal or informal, a "Best Interests" case conference involving all interested parties, and CCGs own complaints process. Where assessments of capacity are disputed, the professionals in charge of the patient's care should consider securing a second opinion, preferably from a different locality.

However, an application to the Court of Protection for a declaration on either capacity, or the lawfulness of a proposed course of action, may be necessary and appropriate as a last resort.

13.5 The Court of Protection deals with disagreements only when they relate to serious decisions, e.g., serious medical treatment or accommodation. In all other circumstances of disagreement or disputes it is the decision-maker who has the responsibility to take the final decision. For the definition of serious medical treatment – refer to paragraph 10.4.2 of the MCA Code of Practice (see link at Paragraph 23).

13.6 Where the decision-maker, employed by CCGs, is of the view that an application to the Court of Protection is appropriate s/he will contact the CCG Legal Services Manager. The CCG may take legal advice and any applications made will invariably be made by the CCG rather than an individual employee.

13.7 Details relating to the remit of the Court can be found in Chapter 8 of the MCA Code of Practice (see link at Paragraph 23).

14. Court of Protection Deputies

14.1 Staff should make themselves aware of the role of the Court (of Protection) appointed deputy and be acquainted with the guidance in Chapter 8 of the MCA Code of Practice. In complex or difficult cases the Court of Protection may appoint a deputy to act as an agent for the incapacitated individual, which may include the final authority to make decisions. The powers of the deputy are directed by the Court. In matters of personal (health and) welfare, it will be a rare occasion that the appointment of a deputy will be required.

15. Advance Decisions to Refuse Treatment (see Chapter 9, MCA Code of Practice)

15.1 Sections 24 - 26 of the Act define and describe the validity and requirements of Advance Decisions. CCG staff responsible for treatment and care are required to acquaint themselves with the law.

15.2 Staff must be aware of their responsibilities in receiving and recording Advance Decisions, whether verbal or written, and seek to establish whether or not an existing Advance Decision is valid and applicable to the individual's treatment or situation. Staff should comply with CCGs Policy on Advance Decisions and Lasting Power of Attorney,

15.3 The document "Useful guidance on Advance Statements and Advance Decisions to Refuse Treatment (Designed by Yorkshire people for Yorkshire People)" is available on the intranet and internet. Link:
http://nww.nyypct.nhs.uk/Directorates/Localities/MCA/FurtherInfo.htm

16. Serious Medical Treatment

(Regulation 4 Mental Capacity Act Regulations 2006)

16.1 The Mental Capacity Act 2005 defines serious medical treatment as:

giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where:

a) 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;

b) a decision between a choice of treatments is finely balanced, or

c) what is proposed is likely to have serious consequences for the patient.

16.2 It is for health professionals to decide, using the above definition and professional judgement, and taking account of the particular circumstances of the patient, whether other treatments should be classified as serious medical treatment, e.g., chemotherapy, amputation, Electro Convulsive Therapy (ECT). Where ECT is proposed professionals should follow their local procedure. Guidance can be found in the MCA Code of Practice paragraph 10.42 - 10.50.

16.3 The Court of Protection Practice Direction 9E gives examples of decision relating to serious medical treatment that should be brought to the Court:

(a) decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state;
(b) cases involving organ or bone marrow donation by a person who lacks capacity to consent; and
(c) cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.

Examples of serious medical treatment may include:

(a) certain terminations of pregnancy in relation to a person who lacks capacity to consent to such a procedure;
(b) a medical procedure performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation to another person;
(c) a medical procedure or treatment to be carried out on a person who lacks capacity to consent to it, where that procedure or treatment must be carried out using a degree of force to restrain the person concerned;
(d) an experimental or innovative treatment for the benefit of a person who lacks capacity to consent to such treatment; and
(e) a case involving an ethical dilemma in an untested area.

Link:http://webarchive.nationalarchives.gov.uk/20110218200720/http://www.hmcourts-service.gov.uk/cms/files/09E_-_Serious_Medical_Treatment_PD.pdf

16.3 Where an incapacitated patient, is 'unbefriended' and serious medical treatment is proposed, an **Independent Mental Capacity Advocate** must be appointed.

17. Independent Mental Capacity Advocates (IMCAs)

17.1 Sections 35 - 41 of the Act impose a legal duty on CCGs and the local authorities to instruct an IMCA for those incapacitated patients who have no relatives, friends or unpaid carers ("the un-befriended") in the following circumstances:

a) With the exception of treatment regulated under Part 4 of the Mental Health Act 1983, where there is a proposal to provide **serious medical treatment** (see Paragraphs 16.1 - 16.4 of this policy) for a person who lacks capacity and there is no one apart from a professional or paid carer for the doctor to consult in determining what would be in the patient's best interest

or

b) The CCG proposes to provide accommodation in hospital for a period of more than 28 days or in a care home for more than 8 weeks

or

c) CCGs propose to change an individual's accommodation to another hospital for a period of more than 28 days or care home for more than 8 weeks (with the exception of Section 117, the provisions of the Mental Health Act 1983 are excluded from the above)

or

d) A Local Authority proposes to provide or change residential accommodation for more than 8 weeks continuously (this only applies to accommodation provided under Section 21 or 29 of the National Assistance Act 1948 or Section 117 of the Mental Health Act 1983 and as a result of the local authority acting under Section 47 of the National Health Service and Community Care Act 1990. With the exception of Section 117, compulsory accommodation under the Mental Health Act 1983 excludes these obligations).

17.2 When to instruct an Independent Mental Capacity Advocate:-

17.2.1 An IMCA **must** be instructed in the circumstances set out in Paragraph 17.1 of this policy.

17.2.3 In addition, an IMCA **may** be instructed at the discretion of the decision-maker in the following circumstances:

1. A care review involving accommodation

or

2. Adult protection cases involving vulnerable people.

17.2.4 Decision-makers will need to consider each case on its own merits to decide whether or not the further involvement of an IMCA would be in the patient's best interests, and this decision must be fully documented. Please see paragraphs 10.59 - 10.68 of the MCA Code of Practice for further guidance (see link at Paragraph 23).

17.2.5 In situations of genuine urgency, where it is immediately necessary to provide treatment or accommodation in hospital, care home or residential home, then this may be done without consulting an advocate.

17.2.6 In urgent cases where an IMCA cannot be instructed beforehand, the reasons for this must be recorded in the patient's clinical notes and a referral must still be made as soon as is practicable.

17.2.7 The decision to instruct an advocate (IMCA) must be taken by the professional proposing the treatment or accommodation after considering the guidance in Paragraphs 16 and 17 of this policy.

17.2.8 Accessing records - IMCAs have a statutory authority to access all relevant records and are therefore not subject to the requirement to apply for access under the Data Protection Act 1998.

17.2.9 In cases where an IMCA is involved, the MCA Code of Practice requires decision-makers to inform the IMCA of the final decision taken, and the reasons for it. Please see paragraph 10.4 of the MCA Code of Practice for more guidance.

18. Instructing an Independent Mental Capacity Advocate

The initial contact with the IMCA service will be according to the procedures currently in operation.

19 Interface with the Mental Capacity Act and the Mental Health Act

19.1 Professionals may be presented with a dilemma as to which of the following statutes is the most appropriate in an individual case:-

Mental Capacity Act
Mental Health Act.

19.2 There will be occasions when informal, incapable, and compliant patients requiring treatment for mental disorder would be appropriately treated under the Mental Capacity Act, e.g., where a mentally incapable patient with profound depression requires ECT but does not require detention and therefore the ECT must, if necessary, be a best interest decision under the MCA rather than a treatment given under part 4 of the MHA. (Ref: Jones MHA Manual, 1-029 -13th edition 2010).

There may be other occasions when detention under the Mental Health Act is necessary to treat the patient's mental disorder and treatment for their physical needs is provided under the provision of the Mental Capacity Act.

19.3 On other occasions, the choice when deprivation of liberty is necessary will be between the MCA DOL Safeguards and the Mental Health Act.

19.4 In circumstances where the incapacity is likely to be short-lived, formal detention under the Mental Health Act or the Deprivation of Liberty may not be appropriate. It is not appropriate to give an urgent authorisation under MCA DOL where there is no expectation that there is a need to apply for a standard MCA DOL authorisation (see MCA DOLS Code of Practice – paragraph 6.3 – see link at Paragraph 23).

20. End of Life

The NHS National End of Life Care Programme has produced a booklet entitled "Capacity, care planning and advance care planning in life limiting illness – A Guide for Health and Social Care Staff". Link: http://www.endoflifecareforadults.nhs.uk/assets/downloads/ACP_booklet_2011_Final_1.pdf

21. Research

21.1 Sections 30 - 34 of the Act make provision for "intrusive" research to be lawfully carried out on, or in relation to, a person who lacks capacity to consent to it, where the research is part of a research project that has been approved by the appropriate body (Sec. 30(4)) and is carried out in accordance with strict rules and requirements. The requirements set out in Sections 32 – 33 of the Act and the relevant guidance must be followed.

21.2 The Research and Ethics Committees should also be acquainted with, and have regard to, Sections 30 - 34 of the Act and the guidance provided in the MCA Code of Practice. As a member of the Research and Development Alliance, CCGs are assured that protocol is fully compliant with the requirements of the Act.

21.2 It is a Department of Health requirement that all proposals relating to intrusive research comply with research governance.

22. Implementation

Dissemination of this policy will take place across the CCGs. Managers have responsibility for ensuring that staff members are sufficiently aware of this policy.

23. Consultation

The Legal Services Manager has been consulted. The following groups previously consulted on this policy:- MCA Policy Review Group, Service Users, Carer, Vulnerable People Team, Governance Committee.

24. References & Links

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RC Psych – The ECT Accreditation Service (ECTAS)
http://www.rcpsych.ac.uk/PDF/The%20ECTAS%20Standards%20Dec%2006.pdf

Tees, Esk and Wear Valley NHS Foundation Trust – Forms

The Office of the Public Guardian
The Office of the Public Guardian – Tel 0300 456 0300
http://www.direct.gov.uk/en/Governmentcitizensandrights/Mentalcapacityandthelaw/index.htm

Mental Capacity Act Code of Practice:-
http://www.justice.gov.uk/downloads/guidance/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

MCA Deprivation of Liberty:-
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Useful Guidance on Best Interest Meetings can be found on the intranet:
http://nww.nyypct.nhs.uk/Directorates/Localities/MCA/BestInterests.htm

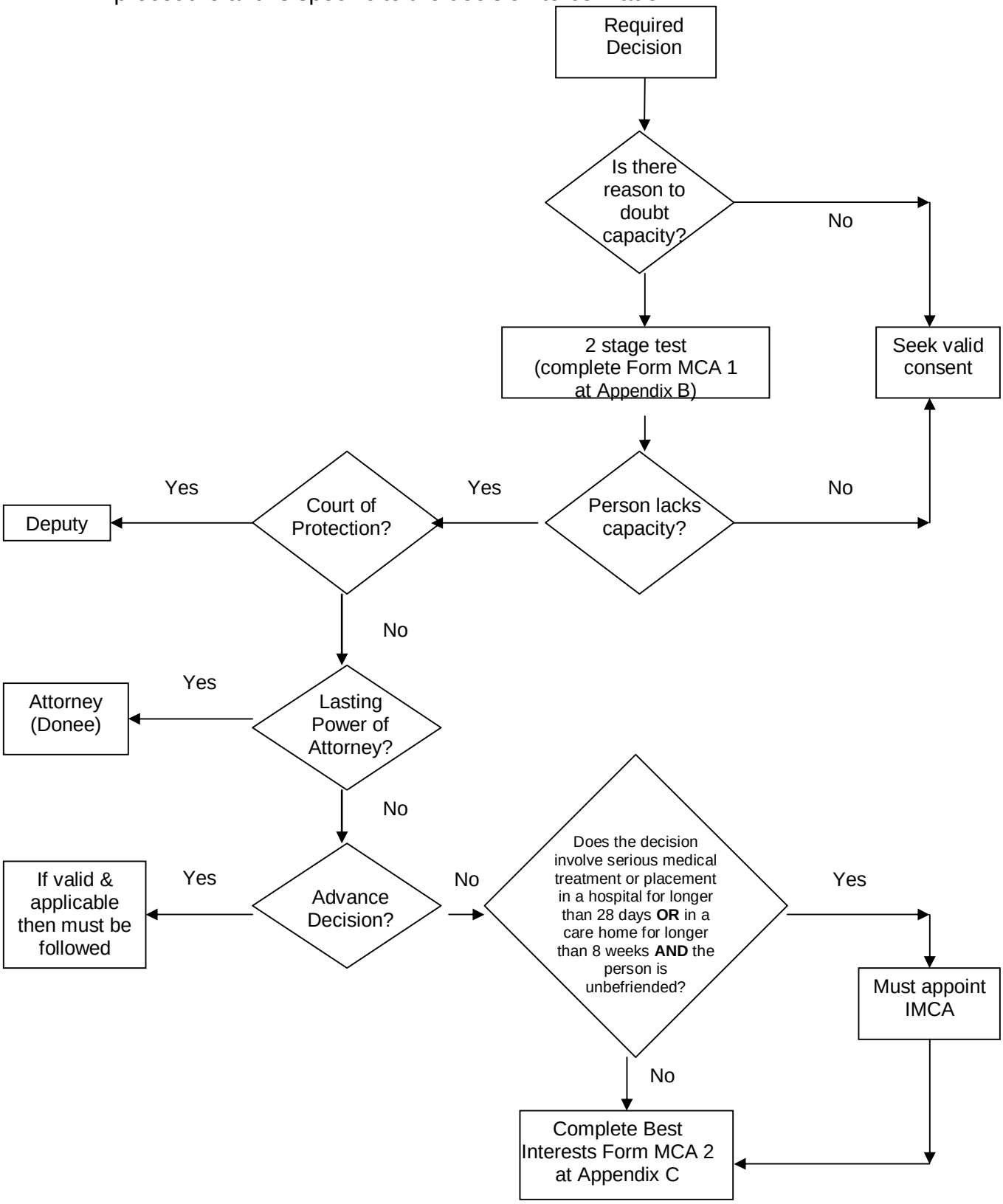
Guidance on Advance Statements and Advance Decisions to Refuse Treatment (Designed by Yorkshire people for Yorkshire People):
http://nww.nyypct.nhs.uk/Directorates/Localities/MCA/FurtherInfo.htm

The NHS National End of Life Care Programme booklet "Capacity, care planning and advance care planning in life limiting illness – A Guide for Health and Social Care Staff":

http://www.endoflifecareforadults.nhs.uk/assets/downloads/ACP_booklet_2011_Final_1.pdf

Appendix A

DECISION-MAKING PATHWAY (See Paragraph 6 of this policy): all adults should be presumed to have capacity unless the opposite has been demonstrated. Consent must be obtained by the person undertaking the procedure and is specific to the decision to be made.



FORM MCA 1 **APPENDIX B**

MENTAL CAPACITY ACT 2005 - RECORD OF ASSESSMENT OF CAPACITY

Every adult should be assumed to have the capacity to make a decision unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made merely on the basis of a Service User's age or appearance, condition or aspect of their behaviour. This assessment document should be completed when concern has been expressed regarding a Service User's capacity to make a specific decision at a particular time.

Service User Name		**Date of Birth**	
Identification Number (eg NHS No., Case Note No.)		**Date of Assessment**	
Name of Decision Maker		**Professional Role**	
Description of the decision to be made:			

Please circle relevant response

STAGE 1 – Determining impairment or disturbance of mind or brain		
Is there an impairment of, or disturbance in the functioning of the Service User's mind or brain? *(For example, symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental disorder, dementia, significant learning disability, long term effects of brain damage, confusion, drowsiness, loss of or reduced consciousness due to a physical or medical condition)*	**NO**	If the answer to this question is NO, there is no such impairment or disturbance, then THE SERVICE USER CANNOT LACK CAPACITY within the meaning of the Mental Capacity Act 2005. PROCEED NO FURTHER WITH THIS ASSESSMENT
	YES	Please detail nature of impairment or disturbance here:

Please circle relevant responses

STAGE 2 – Is the disturbance or impairment sufficient to render the Service User unable to make the specific decision when they need to?	
1) Is the Service User able to understand the information relevant to the decision?	**YES NO**
Rationale:	
2) Is the Service User able to retain the relevant information?	**YES NO**
Rationale:	
3) Is the Service User able to use or weigh the information as part of the decision making process?	**YES NO**
Rationale:	
4) Is the Service User able to communicate their decision?	**YES NO**
Rationale:	
If the answer to any of the above (points 1-4) is NO, then the Service User is considered, on the balance of probability, to lack the necessary capacity to make the particular decision at this time and a Best Interests assessment must be carried out with regard to the decision or act. Arrange a Best Interests meeting with all relevant parties and ensure points in Form MCA2 are considered. Forms MCA1 and MCA2 to be filed in the case notes.	
Outcome:	**Please tick**
1) I reasonably believe that the Service User **does not have** capacity to make the decision.	☐
2) I reasonably believe that the Service User **has** capacity to make the decision.	☐
Signature:	**Date:**

MENTAL CAPACITY ACT 2005 – RECORD OF DETERMINATION OF BEST INTERESTS

Service User Name:		**Date of Birth:**	
Identification Number: (eg NHS No., Case Note No.)		**Date of Assessment:**	
Name of Decision Maker:		**Professional Role:**	
Description of the decision to be made:			

Please circle relevant response

PART 1 – CONFIRMING LACK OF CAPACITY

Has the Service User been assessed as lacking capacity to make this specific decision at this particular time?	**NO**	If the answer to this question is NO, you must complete a capacity assessment and document it appropriately on Form MCA1
	YES	Date of capacity assessment on relevant MCA1: Name of assessor on relevant MCA1:

Please circle relevant responses

PART 2 – DETERMINATION OF BEST INTERESTS

Factors that MUST be considered when carrying out a best interests determination

1. Encourage participation: Have you done whatever possible to permit and encourage the Service User to take part, or improve their ability to take part, in making the decision?	**YES NO**
Comments:	
2. Identify all relevant circumstances: Have you tried to identify all the things that the Service User would take into account if they were making the decision for themselves?	**YES NO**
Comments:	
3. Find out the Service User's views: Have you tried to find out past and present wishes and feelings, beliefs and values, any other factors the Service User would consider if they were making the decision?	**YES NO**
Comments:	
4. Avoid discrimination: have you avoided making assumptions on the basis of the Service User's age, appearance, condition or behaviour?	**YES NO**
Comments:	
5. Regaining capacity: Have you considered whether the Service User is likely to regain capacity and can the decision wait until then?	**YES NO**
Comments:	
6. Life sustaining treatment: Are you clear that any decision you make has not been motivated by the desire to bring about death (no assumptions about the Service User's quality of life)?	**YES NO N/A**
Comments:	
7. Avoid restricting rights: Have you given consideration to options that may be less restrictive of the Service User's rights?	**YES NO**
Comments:	
CONTINUE OVER PAGE	

MENTAL CAPACITY ACT 2005 – RECORD OF DETERMINATION OF BEST INTERESTS

8. Consult others: Have you, where practicable and appropriate, consulted and taken into account the views of others with regard to information about the Service User's wishes, feelings, beliefs and values? a) Anyone previously named by the Service User b) Carer c) Close relatives, friends, others interested in welfare of the Service User d) Attorney/s appointed under LPA or EPA e) Deputy appointed by the Court of Protection f) Other (please specify)	 **YES NO** **YES NO** **YES NO** **YES NO** **YES NO** **YES NO**
Comments (including names of persons consulted)**:**	
9. Other considerations: Is there a valid and applicable Advance Decision in relation to the medical treatment proposed? If so, this must be respected even if it would be in the person's best interests to provide the medical treatment.	**YES NO**
Comments:	

Complete when appropriate

INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA) INVOLVEMENT

An IMCA MUST be instructed in cases where there is no-one appropriate to consult and the decision relates to:

a) NHS to provide or secure the provision of serious medical treatment
b) NHS to place in hospital, or proposes to move to another hospital, for a stay longer than 28 days
c) NHS to place in a care home, or proposes to move to another care home, for a stay likely to be longer than 8 weeks
d) As a result of an assessment under S47 of the NHS and Community Care Act 1990, Local Authority to provide residential accommodation in a care home or its equivalent, or proposes a move to another care home or its equivalent, for a stay likely to be longer than 8 weeks.

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An IMCA MAY be instructed in relation to Adult Protection cases and Care Reviews (seek advice)

Date of Referral to IMCA Service:		**Date of Referral Acceptance:**	
Date Interim Report Received:		**Date Final Report Received:**	
Outcome of IMCA Report:			

OUTCOME OF BEST INTERESTS DETERMINATION	
Having considered all of the relevant circumstances, I reasonably believe that the decision/act detailed is in the Service User's best interests.	**Decision/Act**
Signature:	**Date:**
Form to be filed in case notes	