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Director leads:	Director of Nursing, Clinical Governance and Safety
Contact for advice:	Legal Services

The Mental Capacity Act, 2005
Policy and guidance for service users, carers and practitioners

This policy and guidance should be read in conjunction with the Mental Capacity Act, 2005, and its related Codes of Practice; and the "Making decisions" series of booklets provided by the Department for Constitutional Affairs, the Department of Health and the Public Guardianship Office.

Contents

1.0 Introduction

South West Yorkshire Partnership NHS Foundation Trust is a large and complex organisation which serves over 1 million people and links to Clinical Commissioning Groups and local authorities who also commission our services.

This policy and guidance has been developed to assist staff within the Trust with regard to the complex areas of consent to treatment. This policy specifically relates to powers and duties under the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

All staff providing care and treatment to service users under our care must also be familiar with the Mental Health Act provisions and consent provisions for those patients who have the capacity to consent to treatment.

In addition, this policy refers to policy and guidance related to vulnerable adults, lone working and management of violence and aggression. It is therefore important that all staff familiarise themselves with the content of this document.

2.0 Purpose and Scope of the Policy and procedure

2.1 The underlying philosophy of the Mental Capacity Act 2005 (referred to hereafter as "the Act") is to support individuals in making decisions for themselves and to ensure that an individual who lacks capacity is the focus of any decisions being made, or actions taken on his behalf. It prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person.

2.2 The majority of the Act applies to young people aged 16 and 17, with the entire Act applying to everyone over the age of 18 living in England and Wales. It provides:

- A statutory framework for the assessment of capacity for most purposes and for making decisions on behalf of people who lack capacity.
- For those aged 18 and over, a means, enshrined in law, to make some decisions about their lives in advance, and that these decisions will be binding in the event of the person becoming mentally incapacitated, and therefore unable to make informed decisions at that time. Logically, these decisions are now referred to in the Act as advance decisions.
- For those aged 18 and over, a means to appoint someone else to make decisions relating to property and affairs and/or health and welfare decisions.

2.3 The inability to make a decision can be caused by a range of problems, such as; a mental health problem, dementia, learning disability, and physical problems such as toxic confusion, a stroke, brain injury or the effects of drugs or alcohol. This loss can be of a temporary or fluctuating nature or a permanent loss.

2.4 The assessment of mental capacity and making decisions on behalf of others is a complex process. Those who are involved in assessments of capacity and acting on behalf of others have a duty to ensure their practice is evidence based and in keeping with available guidance. Knowledge of this guidance alone will not be sufficient to ensure practice is defensible, and staff will have to be familiar with the contents of the Act and its associated Code of Practice and related guidance.

3.0 Duties

All staff who are providing care and treatment to services users are responsible for ensuring that the provisions of the Mental Capacity Act 2005, its related codes of practice and available guidance is followed in accordance with this guidance. Where this is not followed, reasons are recorded to reflect the deviation from the policy and guidance.

The lead Directors for this policy are the Medical Director and Director of Nursing, Clinical Governance and Safety. The development of the policy and its updates is supported by the Trust Legal Services department.

Approval of this policy will be sought from the Executive Management Team.

4.0 South West Yorkshire Partnership NHS Foundation Trust's commitment toward people who lack capacity to make decisions

South West Yorkshire Partnership NHS Foundation Trust (hereafter referred to as "the Trust") is committed to enabling people with mental health problems and learning disabilities to access and to ensure that those individuals who lack capacity to make decisions are provided with high quality care from a knowledgeable and competent workforce. This policy and procedure, alongside the implementation of the related Code of Practice, and Department of Health guidance, aims to ensure that staff are aware of the requirements of the Act and are able to use this new legislation to ensure the protection of people who lack capacity to make decisions.

5.0 The Mental Capacity Act; key points

5.1 The Act applies in England and Wales to people aged16 and over but some parts of the Act, notably Advance Decisions to refuse treatment and Lasting Powers of Attorney are limited to those persons aged 18 or over.

5.2 It is based on what at the time was considered to be best practice and largely codifies what was common law in "advanced directives" and "living wills". It clarifies what is meant by lack of capacity and ensures that any decision or action taken on a person's behalf is in that person's best interests.

5.3 The changes it introduced are summarised as follows:

- There must always be the presumption that a person has the capacity to make his own decisions.

- A lack of capacity, and therefore the need to act in a person's best interests, must be clearly determined.
- The Act sets out a two stage test for assessing capacity to make a decision.
- The Act provides a checklist for determining what is in the best interests of a person
- The Act provides new and clearer ways for a person to plan ahead in case he lacks capacity in the future
- Clarification of the actions people can take if someone lacks capacity, and it provides legal protection from civil or criminal action if the Act has been followed
- It places on those working with a person who lacks capacity, a statutory duty to consult other people involved with the person, not just "next of kin" or family members
- Introduces a new statutory advocacy service for people who lack capacity, providing Independent Mental Capacity Advocates (IMCA) who in certain circumstances **must** be consulted, and in other circumstances **may** be consulted.
- Introduces new **criminal** offences of "Wilful neglect or ill treatment of a person who lacks capacity".
- Provides new safeguards concerning research involving people who lack capacity.
- Introduces the new public bodies of the Court of Protection, and the Office of the Public Guardian.
- Introduces a Code of Practice that healthcare practitioners, and others, have a "duty to have regard to".

6.0 Decisions to which the Mental Capacity Act does not apply

Please see chapter 1 of the Code of Practice

Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:

- Consenting to a decree of divorce on the basis of two years' separation
- Consenting to the dissolution of a civil partnership
- Consenting to marriage
- Consenting to sexual relationships
- 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, or
- Giving consent under the Human Fertilisation and Embryology Act 1990.

7.0 Guiding principles

Please see chapter 2 of the Code of Practice

The Act has five key principles which have statutory force. Decisions and actions carried out under the Act should be tested against the principles. These principles provide protection for the person who may lack capacity and those acting on behalf of a person who lacks capacity.

Principle one

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

Principle two

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.

Principle three

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

Principle four

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.

Principle five

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

8.0 Helping people make decisions

Please see chapter 3 of the Code of Practice

8.1 As stated above, the Trust is committed to helping service users make their own decisions, even when circumstances make this difficult. Practitioners must always start from the presumption that a service user has capacity. Providing help with decision making should form part of the care planning processes for people receiving health or social care services.

8.2 Consideration needs to be given to the means of support to help the service user make a decision. The following list is not exhaustive and appropriate support must be developed to meet individual needs:

- Relevant information should be provided in language the person will understand.
- Use of signing, translation, or Makaton should be considered
- It may be more useful to communicate in the person's first language
- Does the person communicate using non-verbal means? This form of communication is equally valid and help should be sought to understand it.
- The person may find it easier to make a decision in a different place (for example at home instead of in a clinic)
- Is advice from a specialist required to help the person make the decision (e.g. a doctor, speech and language therapist, financial or legal advisor)?
- Can relatives, friends or carers help? They may have important advice on how the person communicates, or may be able to communicate better with the person
- Use of technology may help, such as videos, DVDs, photographs etc. to help reiterate points.
- Some people may find it easier to communicate at certain times of the day.
- Is medication affecting the person's ability to communicate?
- Avoid unnecessary time limits.

9.0 Assessing capacity

Please see chapter 4 of the Code of Practice

Valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. Case law ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, if healthcare professionals (or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved. Consent may be given by a patient who has capacity or a donee of a Lasting Power of Attorney for personal welfare/ Court Appointed Deputy providing that the decision is within the scope of the donee/deputy's authority.

9.1 The presumption that all adults have capacity is central to the Act. Where a person has the capacity to make a particular decision the decision is his and cannot be overturned by anyone else. Where there is doubt that a person has capacity to make a particular decision, there is a need to determine this.

9.2 Where there are grounds to doubt a person's capacity to make a particular decision, assessment of capacity must be in keeping with the Act and its related Code of Practice. Any deviance from the guidance contained in the Code of Practice must be logical, rational, reasonable and defensible.

It is important to recognise that a person who lacks capacity can be very articulate and rational in his reasons for making or not making a particular decision. This needs to be considered in relation to the person meeting the test of capacity. For example, a person with a personality disorder may well be able to articulate very well his reasoning behind a particular decision, but his disorder may prevent him from appreciating the consequences of it.

9.2.1 The Act introduces a two stage test at section 2, to assess capacity;

- Does the person have an impairment of the mind or brain?
- Is that impairment or disturbance sufficient to mean that the person is unable to that decision in question at that the time it needs to be made?

9.2.2 This is supported further at section 3(1) stating that "a person is unable to make a decision for himself if he is unable-

a) To understand the information relevant to the decision,

b) To retain that information,

c) To use or weigh that information as part of the process of making the decision, or

d) To communicate his decision (whether by talking, using sign language or any other means)."

9.3 A person may be deprived of capacity for any number of reasons. Capacity is not dependent on any condition alone, but to the effects a condition may have on the ability to make decisions. Whilst the severity of a condition may be a factor in assessment, its severity alone is not the determining factor. For example, a person suffering from a schizophrenic illness may be ill to the extent that he needs to be detained in hospital under the Mental Health Act; however, this does not mean that he necessarily lacks mental capacity.

9.4 A non-exhaustive list of some of the conditions which **may** lead to a lack of capacity to make a particular decision is as follows:

- Acquired brain injury
- Stroke
- Toxic confusional states
- Learning disability

- Dementia
- The effects of an illness or a treatment, such as pain, distress, confusion, drowsiness, unconsciousness
- The effects of drugs or alcohol
- Mental health problems including:
  - Psychoses
  - Anxiety
  - Phobias
  - Depressive illness
  - Other mood problems
  - Personality disorder

9.5 Mental capacity is **decision and time specific.** A person is considered to have capacity for each and every decision he makes. The decision to act in a person's best interests because a lack of capacity has been identified is only for the particular decision at the time it needs to be made.

9.6 Loss of capacity may be temporary or open to fluctuation such as in the case of a diurnal variation. The capacity to make decisions may also be effected by alcohol, drugs; over the counter, prescribed and illicit, it may also be affected by the environment.

10.0 Recording assessments of capacity

10.1 There are no statutory or standard forms for the recording of an assessment of capacity in relation to the Act. The Local Social Services Authorities aligned with the Trust have developed recording forms for the purposes of documenting assessment of capacity. These forms may be used when those assessing capacity consider that such a form would be useful. http://nww.swyt.nhs.uk mental capacity act

10.2 It is acceptable to record an assessment of a patient's capacity within the medical or Rio notes. Any such record should state what the decision was and, if the patient lacks capacity, on what grounds the patient lacks capacity.

10.3 This record should include a statement as to whether the patient is expected to regain capacity and if the decision can be deferred until such a time as the patient regains capacity.

10.4 If a decision needs to be made at the time then the best interest decision should also be recorded. A best interest decision form can be found @ http://nww.swyt.nhs.uk

10.5 In most cases assessment of capacity will take place on a regular, more informal level; however, it is important to appreciate that the test for

capacity and the principles to be applied in decision making remain the same and practitioners may still be called upon to justify decisions.

10.6 It is suggested that the form may be of benefit to use in the following circumstances when:

- The decision is about serious medical treatment
- The decision concerns long term accommodation changes
- There is a lack of concurrence about whether or not the person lacks or has capacity
- There is an intention to refer to the Independent Mental Capacity Advocate
- There is a need to have a specific record of the assessment and the rationale behind it suggests that such a form would be useful.
- It is requested by the police for the purposes of furthering their enquiries (e.g. s44 Mental Capacity Act charges)

10.7 When recording the assessment of capacity of a voluntary patient in preparation for ECT, in the first instance Form 4 should be used to record the assessment, thereafter the ECT record of capacity held within the treatment record booklet should be completed. (For further information refer to the ECT protocol.)

10.8 It is important to note that because assessment of capacity and judgment of best interests is decision and time specific, it is not possible to write anticipatory care plans which state whether or not a person has capacity and what is in his best interests. Care plans need to indicate what issues should be considered in assessing capacity and what should be considered when judging best interests. Entries in the notes relating to the implementation of the care plan must make reference to the Act.

10.9 In cases where an external team or service have requested assistance with an assessment of capacity (such as a request from an acute trust in the case of a patient under their care who also has a mental disorder) the records should show the context of the assessment. In such cases trust staff would be offering an opinion and would not be responsible for the assessment of capacity or any ensuing best interest decision. The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins therefore the responsibility for assessment and decision making would remain with the acute trust and their decision maker.

11.0 Duty to consult as far as is practicable and appropriate

Please see chapter 5 of the Code of Practice)

11.1 The Mental Capacity Act extends the duty to consult other people in relation to considering best interests. The duty to consult is not restricted to consulting with the person's next of kin, therefore it should be checked whether or not the person has set out his views in a document, appointed a person to act on his behalf, or if there are others such as friends or family involved in his care. If practicable and appropriate you must consult with, and take in to account, the views of the following:

- Anyone the person has previously nominated to be consulted (The Nominated Person)
- Lasting Power of Attorney appointed
- Enduring Power of Attorney appointed
- A Deputy appointed by the Court of Protection
- Professionals involved in the care of the person
- Other persons engaged in caring for, or interested in, the person. This could be carers, friends, supporters, a solicitor or other professional person who has involvement with the person.

11.2 Consideration must be given as to the need to consult further. Depending on the nature of the decision and the seriousness of the consequences, the consultative body for decisions, **may** include specialist advisors, such as speech and language therapists, mental health professionals, specialists in learning disabilities, psychologists etc.

11.3 Reasons why consultation may not be practicable or appropriate may include the following:

- The person lives abroad and has no contact with the service user
- A relative who is estranged
- A family member who refuses to be consulted
- A family member who himself lacks capacity to be involved in the process
- The urgency of the decision, therefore a lack of time
- There is an abusive relationship the person and the individual available to consult with
- The service user is strongly opposed to the other person's involvement

Confidentiality continues to apply and must be considered before and during any consultation with others. (Refer to paragraph 13 below)

11.4 At times consultation will raise the issue of conflicting views between consultees. This may be as a consequence of the emotive nature of the decision to be made or values and beliefs. Staff should be supportive to the concerns of the family and friends consulted, and where possible offer

face to face meetings, mediation or the involvement of an advocate. Ultimately consultees if unhappy with actions taken by trust staff should be provided with details of the Trust complaints procedure.

11.5 Whist staff should consult with those who best know the patient who lacks capacity before making best interest decisions in respect of care and treatment it should be remembered that unless the person has an advance decision or there is a Donee or Court Appointed Deputy with the authority to make the decision in question, the best interest decision rests with the lead clinician (the decision maker).

11.6 Staff should also be aware of the potential of abusive relationships and in such cases should invoke the Vulnerable Adults policy.

11.7 At times the opinions of the patient's family and friends will conflict with valid and applicable advance decisions made by the patient. In such cases unless the Consultees raise information that would call into question the validity or applicability of the advance decision the care team must follow the patients advance refusal of treatment as set out in the advance decision. Staff should be supportive to the concerns of the family and friends consulted, and where possible offer face to face meetings, mediation or the involvement of an advocate. Consultees if unhappy with actions taken by trust staff should be provided with details of the Trust complaints procedure. Advice is available in such instances from Legal Services (01924-327080)

11.8 In cases where no resolution can be found to such a dispute in respect of an advance decision and there is a need to proceed with a treatment the Trust will take the case to the Court of Protect for a decision. In such instances Legal Services will co-ordinate legal proceedings.

11.9 All instances of disputes and disagreements in respect of best interest decisions including those from within the care team, must be recorded in the patient's medical notes and RiO; how the dispute was resolved, what best interest decision was made and by whom

12.0 Best interests

Please see chapter 5 of the Code of Practice

12.1 It is important to remember that where a person lacks capacity to make a particular decision, he can neither consent to it nor refuse it. Any person acting on behalf of a person who lacks capacity **must** act in that person's best interests. The ability to articulate a decision, consent or refusal is not the single determining factor in determining capacity or best interests. Some conditions may enable a person to be very articulate but he may still lack the ability to make an informed decision and therefore lack capacity.

12.2 It is important to consider the following factors when determining best interests:

- What is the decision about?
- Is there a Nominated Person?
- Is there a Lasting Power of Attorney?
- Is there an Enduring Power of Attorney?
- Who needs to be involved in making the decision?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?
- What is known about the person's previous wishes, feelings and beliefs?
- What are the person's current wishes feelings and beliefs even though lacking capacity?
- What are the practical implications of making decisions in a person's best interest?
- What are the risks involved?

12.3 There are no statutory or standard forms for the recording of a best interest decision. Local forms have been developed by the Local Social Services Authorities aligned with the Trust http://nww.swyt.nhs.uk. There is no requirement that these forms be used but staff may find it useful in working systematically through the best practice checklist and recording their rational for future reference.

12.4 In instances where staff are managing or assisting with the management of a person who has self-harmed, where the person is able to communicate, an assessment of their mental capacity should be made as a matter of urgency. If the person is judged not to have capacity, then they may be treated on the basis of temporary incapacity (see chapter 2, paragraph 12).

12.5 Similarly, patients who have attempted suicide and are unconscious should be given emergency treatment if any doubt exists as to either their intentions or their capacity when they took the decision to attempt suicide.

12.6 However, patients with capacity **do** have the right to refuse life-sustaining treatment (other than treatment for mental disorder under the Mental Health Act 1983) – both at the time it is offered and in the future. Making a decision which, if followed, may result in death does not necessarily mean that a person is or feels suicidal. Nor does it necessarily mean that the person lacks the capacity to make the decision now or in advance. If the person is clearly suicidal, this may

raise questions about their capacity to make the decision. If a patient with capacity has harmed themselves, a prompt psychosocial assessment of their needs should be offered. However, if the person refuses treatment and use of the Mental Health Act 1983 is not appropriate, then their refusal must be respected. Similarly, if practitioners have good reason to believe that a patient genuinely intended to end their life and had capacity when they took that decision, and are satisfied that the Mental Health Act is not applicable, then treatment should not be forced upon the person, although clearly attempts should be made to encourage them to accept help. A best interest decision form can be found at http://nww.swyt.nhs.uk mental capacity act

13.0 Record keeping

Please see chapter 4 of the Code of Practice paragraph 4.61

13.1 All those involved in the care and treatment of a person who may lack capacity should keep a record of long term or significant decisions made about capacity. The record should be made in the place where details about a service use are regularly made, such as RiO or the medical notes. The record should show:

- The decision
- Why the decision was made
- How the decision was made
- Who was involved
- What information was used

13.2 Recording decisions in this way will help staff to demonstrate why they had a reasonable belief in the person's lack of capacity and that they were acting in the person's best interests.

13.3 Where a person is judged to lack capacity to consent to day-to-day care, elaborate record keeping is not required. However, if a member of staff's decision is challenged, the practitioner must be able to describe why he had a reasonable belief of lack of capacity and about what was in the person's best interests. The decision about lack of capacity and best interests should always be recorded in the person's case notes. Although this does not need to be done on a daily basis, the record should record the decisions and note that it will be reviewed regularly or until capacity is regained.

13.4 It is important to note that where a service user lacks capacity to make a particular decision, e.g. for treatment, or sharing information, then he cannot sign a consent form or any other document relating to consent or

refusal. In these cases, those acting on his behalf must act in the person's best interests and records should reflect this.

14.0 Care Planning

Please see chapter 6 of the Code of Practice paragraph 6.34

14.1 Assessment of capacity and judgement of best interests is decision and time specific, it is not possible to write anticipatory care plans which state whether or not a person has capacity and what is in his best interests. Care plans need to indicate what issues should be considered in assessing capacity and what should be considered when judging best interests. Where a care plan is used, entries in the notes relating to the implementation of the care plan must demonstrate the implementation of the Mental Capacity Act.

14.2 It is however possible to describe an approach to assessing capacity and considering best interests, which will assist in recording when such assessments and decisions are made.

14.3 Consideration should be given to writing Advance Care Plans when the person has the mental capacity to participate in the process.

14.4 Advance Care Planning is described as a process of discussion between an individual and their care providers irrespective of discipline or agency. If the individual wishes, their family and friends may be included. This should be conducted with regard to the CPA policy. An Advance Care Plan might include:

- The individual's concerns
- His important values or personal goals for care
- His understanding about his illness and prognosis
- His preferences for types of care and treatment that may be beneficial in the future and the availability of these.

14.5 Advance care planning normally takes place in the context of an anticipated deterioration in the individual's condition in the future, which may lead to a loss of capacity to make decisions. The patient should be offered the opportunity and assistance to make an advance decision and supporting advance statements of wishes. The person may also wish to make a Lasting Power of Attorney, support to access legal advice should be provided. Care should be taken to ensure the patient understands the extent of the authority of these documents and in which circumstances they can be over ruled.

15.0 Confidentiality and data protection

Please see chapter 16 of the Code of Practice

15.1 This part of the policy should be read in conjunction with the Data Protection Policy. This policy does not replace the guidance of the Information Commissioner's Office on the Data Protection Act 1998. Where there is doubt advice should be sought.

15.2 Service users have a right to confidentiality. Information can be shared about an individual where the service user has capacity and agrees to sharing information, where there is a legal duty to do so, or where there is an overriding public interest.

15.3 Where a person lacks capacity to make a decision regarding sharing of information, the following guidance applies (alongside the guidance contained in the Data Protection Policy)

- Information can be shared if it is in the best interest of the person who lacks capacity to do so. This should be limited to the information which is needed to meet the person's best interests.
- Independent Mental Capacity Advocates have a right to access relevant health and social care records.
- A person may have previously given consent (whilst he had the capacity to do so) for a person or persons to access information, such as a Lasting Power of Attorney or Enduring Power of Attorney. In such cases those disclosing information should be clear about the extent of the Powers.
- A Deputy appointed by the Court of Protection may have the right to relevant information
- A person may have previously let his wishes and feelings be known about sharing information, and these must be considered when considering sharing information for a person who lacks capacity.

If there is any doubt about sharing information, advice should be sought.

16.0 Mental capacity and risk management

16.1 It is a fundamental principle that people live with elements of risk in their personal lives. When considering what action is in the best interests of a person assessed as lacking capacity to make a decision, there is a need to take into account a balance of that person's risks and needs.

16.2 It is important when assessing capacity as part of assessment, that a person is able to understand the risks associated with making a decision one way or another, or indeed, of not making a decision. Understanding and accepting risks is an important part of decision making. If the person

is unable to understand the risks of a decision, it is likely that he lacks capacity.

16.3 When considering risk taking behaviour, assessors must deliberate whether the person fully understands the consequences of a proposed decision. This includes the person understanding and believing information provided and any negative consequences of the proposed decision.

16.4 Where a person's risk taking behaviour may lead to risk to other people, public protection must be considered. If the behaviour is likely to imperil children and young people under the age of 18 reference should be made to the Trusts Safeguarding and Promoting the Welfare of Children Policy

16.5 It is equally important that those who lack capacity to make decisions are protected from risks as a result of their incapacity. This may mean that sometimes actions are taken, against the person's apparent (although incapacitated) wishes

16.6 There may be occasions when staff themselves face risks associated with assessing capacity and determining best interests. It may be that there are family disagreements or disputes or carers feel strongly about the decisions to be made or disagree with the decisions taken by professionals. These risks must be taken seriously and staff and their managers should address such risks. Where required reference should be made to the Trust Lone Worker Policy and to the Management of Violence and Aggression

17.0 Protection of vulnerable adults

17.1 This part of the Policy should be read in conjunction with the Safeguarding Adults Policy.

17.2 People who lack capacity are amongst the most vulnerable people in our community. It is important to recognise that where a person's ability to make some decisions is impaired, the decisions he is able to make, become more important.

17.3 Mental capacity will often need to be considered in cases where adult abuse is suspected or proven. A person with capacity will be able to make a decision about his future care and support, even if this means that he wishes to remain within an abusive environment. If however a person in an abusive situation lacks capacity, then those involved will need to make decision on his behalf based on that person's best interests. This may mean a complex set of circumstances will need to be considered, up to and including the effects of the person remaining within the abusive environment and the effects of removing him from the environment. The wider social aspects of a person's circumstances must be considered when determining what is in his best interests

17.4 Section 44 of the Mental Capacity Act relates to wilful neglect or ill treatment of a person who lacks capacity, and makes these criminal offences (see paragraph 26 below, wilful neglect or ill treatment of a person who lacks capacity). These offences may need to be considered in cases of adult protection. (See Trust policy Protection of Vulnerable Adults).

18.0 Independent mental capacity advocate

Please see chapter 10 of the Mental Capacity Act

18.1 Local Authorities are responsible for the commissioning of Independent Mental Capacity Advocacy Services (IMCA). The organisation "Together for Mental Wellbeing" provides the service throughout Wakefield and Kirklees, and "Cloverleaf" provides the service for Calderdale and Barnsley at the date that the policy was written (see paragraph 25 below, Interface with the Mental Health Act).

18.2 Referral to the IMCA service is restricted to a set of defined circumstances, as it is designed to assist the most vulnerable members of society who not only lack capacity, but who also have no friends, carers or supporters, or those who may be involved in adult protection cases.

18.3 The IMCA service is for people who lack capacity and who do not have friends, carers or supporters and there needs to a decision taken about serious medical treatment **or** consideration is being given to moving the person into long term accommodation (defined as more than 28 day in hospital or 8 weeks in a care home). In these defined sets of circumstances, staff a have legal **duty** to instruct the IMCA.

18.4 The IMCA **may** be instructed in cases where a care review is to consider movement from one care home to another, providing the person concerned lacks capacity to make the decision and there is no one other than a paid carer for the current care team to consult with.

18.5 The IMCA **may** also be instructed where the person who lacks capacity is the subject of adult protection procedures, whether or not the person is without friends or relatives for the care team to consult with. This referral should be considered where it is thought to be of some benefit to the case.

18.6 Guidance on who to refer, how to refer and to which service are included within the Trust Intra-net "Mental Health Law" pages

19.0 Planning ahead for the future

Please see chapter 7 of the Code of Practice

19.1 A person can plan ahead for a time when he may lack capacity. The Mental Capacity Act provides three ways of doing this.

19.2 This is a particularly complex area and staff involved in implementing this part of the Act are advised to consider carefully the guidance contained within the MCA Code of Practice and Chapter 9 of the MHA Code of Practice; Wishes expressed in advance.

19.3 Ways to plan ahead can be through:

- Lasting Powers of Attorney
- Advance decisions to refuse treatment
- Statement/s of wishes, feelings and beliefs

20.0 Lasting Power of Attorney

Please see chapter 7 of the Code of Practice

20.1 The Mental Capacity Act introduces new ways in which a person can plan ahead in case he loses capacity in the future. Lasting Powers of Attorney replace and expand the system of Enduring Powers of Attorney. From October 2007, only the new Lasting Powers of Attorney can be created. If however, a person has already made an Enduring Power of Attorney and it has not been registered, it can still be registered after 2007 and will basically take effect as a Property and Affairs Lasting Power of Attorney. The effect of this is that for many years both systems will be in place.

20.2 There are two types of Lasting Power of Attorney (LPA):

- Property and affairs LPA
- Personal Welfare LPA

20.3 The property and affairs LPA is similar to an EPA. It only relates to financial matters and can be used when the person still has capacity if that power is given to the attorney

20.4 The personal welfare LPA can only be used when the person who created it lacks capacity

20.5 LPA can only be made when the person making it is aged 18 or over, has the capacity to understand the importance of the document, and the power they are giving to another person. The person to whom the Power has been given is known in the Act as the “donee” but is also known as an Attorney. Attorney is the term used in the Code of Practice. There can be more than one attorney appointed and they may be allowed to act independently or only together.

20.6 The personal welfare LPA, means that for the first time a person can nominate another person to make decisions on his behalf in relation to both health, and personal welfare

20.7 It is essential to read the LPA, to understand the extent of the Attorney’s power and any restrictions or limitations placed on his decision making authority.

20.8 Before an LPA can be used it must be registered with the Office of the Public Guardian (see paragraph 29 below, The Office of the Public Guardian). Without registration an LPA cannot be used. An Attorney should be able to produce the relevant documentation from the Office of the Public Guardian. It will have an official seal stamped on every page.

20.9 If there is doubt about the validity of an LPA the Trust legal services should be contacted, who will provide support and advice including where necessary contacting the Office of the Public Guardian on behalf of the Trust

20.10 If the person who lacks capacity has created a personal welfare LPA, the Attorney is the decision maker on all specified matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority, the Attorney has the authority to make personal welfare decision and consent to or refuse treatment on the donor's behalf.

20.11 The Attorney must act in the person's best interests and if there is a dispute that cannot be resolved, it may be referred to the Court of Protection

20.12 If the decision is about life sustaining treatment, the Attorney only has the authority to make the decision if the LPA specifies this.

20.13 In cases where a matter is referred to the Court of Protection for a decision, in respect of an LPA the Act provides that life sustaining treatment can always be given while the application is being made

20.14 Enduring Powers of Attorney only relate to property and affairs and do not give the person with the Power of Attorney the right to make health or welfare decisions on behalf of a person without capacity; however the Attorney should be consulted on matters of serious medical treatment.

20.15 Enduring Power of Attorney (EPA) can be used when the person who has made the EPA still has capacity if permitted by the EPA.

20.16 Employees of the Trust must not agree to be an Attorney for a service user for whom they are providing care, treatment or support. In order to avoid the possibility of members of the patient's family raising issues about the reason for and nature of the involvement of staff, Trust employees should not assist with the wording of an LPA or provide a certificate of competence for the maker but rather direct or support the patient to seek legal advice.

21.0 Advance decisions to refuse treatment

Please see chapter 9 of the Code of Practice

21.1 Previously commonly known as living wills, or advance directives, these documents existed prior to the enactment of the Mental Capacity Act. The MCA clarifies the legal status of these decisions, now known as Advance

Decisions, Advance Statements and Advance Decision to refuse Life Sustaining Treatment, and sets out how they should be made. People can make an advance decision to refuse specified treatment (but not basic care – see paragraph 19.9 below) in the future which may include refusal of life sustaining treatment.

21.2 An advance decision to refuse treatment can only be made by a person aged 18 or over who has mental capacity at the time the advance decision is made. If the advance decision is valid and applicable, then it has legal force. An advance decision may be verbal or in writing whilst an advance decision to refuse life sustaining treatment must be in writing. It must be signed by the maker in the presence of a witness who must also sign it. It can be in any format and might be in the person's medical notes. (see 19.6 below) In both cases the decision must set out the circumstance in which the refusal will apply and the specific treatment that the person is refusing. A form to help a person make a mental health specific advanced decision can be found http://nww.swyt.nhs.uk

21.3 An advance decision to refuse treatment may be given by the person verbally to a member of staff. In such instances the member of staff should record the decision and any witness to the verbal advance decision. The care team must review this decision in detail with the person to ensure the exact intention of the decision is understood by all concerned.

21.4 Advance decisions can avoid the need for clinicians to make difficult decisions and for them to be sure they are acting in accordance with what the service user wanted. They offer the additional benefit of facilitating participation and joint care planning for a time in the future when the person may lack the capacity to engage in discussion and make decisions in respect of treatment.

21.5 Staff should not act as a witness to an advance decision. Service users should be encouraged to discuss any advance decisions with family, friends or external carers, to ensure that they are interpreted as the service user intended and to avoid family dispute in the future.

21.6 Advance decisions to refuse life sustaining treatment must be verified by a specific statement that says the advance decision is to apply to the specified treatment even if life is at risk. This statement must also be in writing, signed by the maker and the signature must be witnessed unless it is contained in the same document as the advance decision. If a person has already made an advance decision to refuse treatment, he should be advised and encouraged to review it in light of the requirements of the Mental Capacity Act.

21.7 If Trust staff are in a position to action an advance decision to refuse treatment, they must consider if the refusal is both valid and applicable in

the current circumstances. In considering the validity of an advance decision, staff should have regard to the following:

- Has the advance decision been withdrawn in the period between making it and the need to action it?
- Has it been overridden by the making of a Lasting Power of Attorney?
- Has the person acted in a way which is inconsistent with the advance decision, e.g. by making comments about his future?
- If it is about life sustaining treatment, is it signed, witnessed and contains or is accompanied by a statement recognising that it applies to life sustaining treatment?

21.8 In considering the applicability of the advance decision, practitioners should have regard to the following:

- Does the advance decision specify the treatment which is being refused, whether in lay or medical terms?
- Does the advance decision to refuse treatment specify any circumstances which will apply, and are those circumstances currently present?
- Are there any reasonable grounds for believing that there have been changes in circumstances which would have affected the person's advance decision (e.g. advances in medical treatment)?

21.9 A person cannot make an advance decision to refuse basic or essential care, such as warmth, cleanliness, offer of oral food and fluid. Note that artificial nutrition, such as feeding via a naso-gastric tube and fluid is treatment and can be refused.

21.10 A person cannot make an advance decision to demand a specific medical treatment, he can only refuse treatment. If a person has made a statement, indicating that he has preferred treatments, these should be given due consideration when determining his best interests.

21.11 A person cannot make advance decisions which demand his life to be ended.

21.12 An advance decision that does not fulfil the requirements to be valid and applicable is not binding but should still be taken as an advance statement when considering any best interest decision – see the next section.

21.13 In cases where a matter is referred to the Court of Protection for a decision in relation to the validity or applicability of an advance decisions the Act provides that life sustaining treatment can always be given while the application is being made.

21.14 Advance decisions to refuse treatment for a mental disorder can be over ruled by Part 4 of the MHA

22.0 Statements of wishes, feelings and beliefs

22.1 These are a formal way for an individual to make known his personal desires in respect of his care and treatment. They assist family, friends, and professionals determine best interests, should that person lose capacity. It must be borne in mind that these are desires. An individual cannot demand that they are met. They can include anything that is important to the person e.g. the need for a vegetarian diet, religious practices, or the wish to have a pet looked after, or moved with the person into residential care. They can also indicate the type of treatment a person would like to have for a particular disorder, including specific drugs or other treatments.

22.2 Those making best interest decisions on a person's behalf have a legal duty to have regard to such a statement in considering that person's best interests. Not complying with the statement must be for reasonable and rational reasons related to the final decision of the best interests of the person.

22.3 Statements of wishes, feelings and beliefs need not be in writing, but those that are written down and given to family, friends and health and social care professionals are more likely to be known about and followed.

22.4 Where staff are involved with a person who wishes to plan for the future, they should give advice, support and assistance if the person wishes to make such a statement. A form to help a person make his mental health care specific, wishes, feeling and beliefs known is contained in http://nww.swyt.nhs.uk

23.0 Restraint

Please see chapter 6 of the Code of Practice. This section should be read in conjunction with paragraph 25, Interface with the Mental Health Act

23.1 Section 6 of the Mental Capacity Act defines restraint as the use or threat of force when an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person lacking capacity, and that any restrain used is **proportionate** to the **likelihood** and **seriousness** of the harm. If restraint is used in this way, then those undertaking it are protected by the Mental Capacity Act.

23.2 The Mental Capacity Act (section 6(5)) makes it clear that the Act does not provide protection for an action which deprives a person of his liberty within the meaning or the Human Rights Act. Any action which deprives a person of his liberty without using legislation will be reported under the Safeguarding Adult Procedures.

24.0 Research

Please see chapter 11 of the Code of Practice

24.1 The Mental Capacity Act sets out parameters for research which may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees it is safe, related to the person's condition and produces a benefit to the person that outweighs risk/burden. The Trust is part of West Yorkshire Mental Health Research Consortium and its research governance is fully compliant with the Act.

24.2 Carers or nominated third parties of an incapacitated person must be consulted and agree. If the person shows any signs of resistance or indicates in any way he does not want to take part, he must be withdrawn from the research.

25.0 Interface with the Mental Health Act

Please see chapter 13 of the Code of Practice

25.1 The Mental Capacity Act can be used to treat a person for mental disorder when he cannot consent because he lacks capacity, and where the treatment is in his best interest.

25.2 The Mental Capacity Act cannot be used to detain a person in hospital. Where a person needs to be detained because he is suffering from a mental disorder, then he is assessed with a view to detention under the Mental Health Act.

25.3 If a person is detained under the Mental Health Act, the Mental Capacity Act becomes subordinate legislation and therefore treatment can be given for mental disorder without the patient's consent in accordance with Part 4 of the MHA.

25.4 The MHA Code of Practice states (17.8) even where clinicians may lawfully treat a patient compulsorily under the Mental Health Act, they should where practicable, try to comply with the patient's wishes as expressed in an advance decision.

25.5 The Mental Health Act 1983 as Amended by the Mental Health Act 2007 recognises the authority of an advanced decision to refuse ECT under s58A (See the Trust ECT protocol); however the powers contained within s62 MHA may override the advance decision to refuse ECT

25.6 The Mental Health Act 1983 as Amended by the Mental Health Act 2007 recognises the authority of the advance decision in respect of community patients who are subject to compulsion

25.7 Where a person who is subject to the Mental Health Act is moved to another hospital or care home under the provisions of the Mental Health Act, there is no requirement to consult an Independent Mental Capacity Advocate

25.8 For most other purposes, the Mental Capacity Act will still apply to those detained under the Mental Health Act, for example for the treatment of physical disorders.

26.0 Children and Young People aged 16 – 18

Please see chapter 12 of the Code of Practice.

26.1 There is an overlap between the Mental Capacity Act and the Children Act for 16 and 17 years, and most of the provisions of the Mental Capacity Act apply. Decisions made on behalf of young people aged 16 and 17 must be in their best interests when they lack capacity and the decision makers should normally consult those with parental responsibility.

26.2 Parts of the Mental Capacity Act do not apply to young people aged 16 and 17. A young person cannot make a Lasting Power of Attorney or an advance decision to refuse treatment. The Court of Protection has no power to make a will on behalf of a person under 18.

26.3 For those under 16, only two parts of the Mental Capacity Act apply. The Court of Protection can make decisions relating to property and affairs of a person under 16, and the criminal offences of wilful neglect or ill treatment of a person who lacks capacity apply to all age groups.

27.0 Disputes and disagreements

Please see chapter 15 of the Code of Practice

27.1 The Code of Practice makes it clear that any disputes relating to either assessment of capacity or best interest need to be resolved quickly and in a cost effective manner.

27.2 It is likely that there will be challenges in relation to both assessments of capacity and best interest decisions. These issues can be very emotive subjects for those who care for a person who lacks capacity. It is possible that there may be disagreements where the carer(s) have a different opinion from professionals on capacity or best interests, or where families disagree with each other. It is also possible that there will be several opinions as to what action is in a person's best interests, and it may be difficult to get a consensus opinion on the best action to take

27.3 It is important to try to resolve disagreements and disputes at a local level. Good communication and open dialogue are important but it is recognised that issues may not always be resolved at this level.

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

27.5 A case conference or mediation may be useful. Where agreement cannot be reached assistance is sought from the employee's line manager or senior manager, further meetings may be necessary including seeking legal advice.

27.6 If agreement cannot be reached, the family or carers have recourse to the complaints procedures of the agencies involved

27.7 Recourse to the Court of Protection should be the last resort if no agreement can be reached. When seeking a court declaration contact the Director of Nursing, Compliance and Innovation or the Assistant Director Legal Services

28.0 Wilful neglect or ill treatment of a person who lacks capacity

Please see chapter 14 of the Code of Practice.

28.1 Section 44 of the Mental Capacity Act (2005) creates new criminal offences of wilful neglect or ill treatment of a person who lacks capacity. These are punishable by a fine or a sentence of up to five years imprisonment or both.

28.2 These offences may apply to anyone caring for a person who lacks capacity – this includes family, carers, health or social care staff in hospital, care homes and those providing care or support in a person's home.

28.3 Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, he must either:

- have deliberately ill treated the person, or
- be reckless in the way he was treating the person

28.4 It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

28.5 The meaning of wilful neglect varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act he knew he had a duty to do.

28.6 Where ill treatment or wilful neglect is suspected, the police must be informed and the Safeguarding Adults Procedure should be instigated.

29.0 Protection from liability

Please see chapter 6 of the Code of Practice.

29.1 Section 5 of the Mental Capacity Act (2005) allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. This is to ensure that acts can be carried out in a person's best interest where he lacks capacity.

29.2 To ensure protection from liability, it is important that those acting on behalf of others observe the five principles of the Mental Capacity Act and act reasonably in assessing capacity and in determining and carrying out best interest decisions. The decision maker is treated as being in the same position as if the individual they are acting for had capacity and had consented to the action.

29.3 Those involved in the provision of care, support or treatment of a person who lacks capacity have a legal duty to have regard to the guidance contained within the Code of Practice. Staff should follow the guidance in the Code of Practice unless there are rational and justifiable reasons for not doing so. There are no specific legal sanctions in a failure to comply with the Code but failure to do so will be used in any disciplinary proceedings and can also be used in evidence before a court or tribunal or in any civil proceedings.

29.4 South West Yorkshire Partnership NHS Foundation Trust expects that the practice of its employees will be in keeping with the guidance contained in the Code of Practice, unless there are justifiable reasons for deviating from it. Any deviation from the Code of Practice and the reasons for this must be clearly recorded.

29.5 For these reasons, the Trust expects that that staff who work with people who lack capacity are familiar with the contents of the Code of Practice.

30.0 The Court of Protection

Please see chapter 8 of the Code of Practice.

30.1 The Court of Protection has jurisdiction relating to the whole of the Mental Capacity Act and is the final arbiter for capacity matters. It has its own procedures and nominated judges. In cases where there are particular concerns or an agreement cannot be reached relating to capacity or best interests, the Court of Protection can be consulted to make a judgement.

30.2 This will deal with all serious unresolved matters relating to capacity welfare, finance, serious medical treatment and protection. The Court can make a decision where there is a single issue or appoint a Deputy where there are ongoing issues.

30.3 In cases where a matter is referred to the Court of Protection for a decision, including questions about advance decisions and/or LPAs the Act provides that life sustaining treatment can always be given while the application is being made

31.0 The Office of the Public Guardian

Please see chapter 14 of the Code of Practice.

The Public Guardian and his staff are the registering authority of LPAs and deputies. They supervise deputies appointed by the Court of Protection and provide

information to the Court to help make decisions. They also work together with other agencies such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges his duties.

32.0 Deprivation of Liberty

To be read in conjunction with the DoL Safeguards

32.1 The Mental Health Act (1983) as Amended by the Mental Health Act (2007) amends the Mental Capacity Act to incorporate the Deprivation of Liberty (DoL) Safeguards. The Safeguards are intended to protect the interests of those people who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, who are deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights within either a hospital or registered care home setting.

32.2 A deprivation of liberty arises when a person who has a mental disorder and lacks capacity to consent to being in hospital or a care home for the purposes of their care or treatment is being kept in such a setting. Furthermore, he would be prevented from leaving if he were to try and do so and as a consequence of him lacking capacity to consent to the care or treatment that he is receiving, staff can be said to have full and effective control of his care and treatment. This would mean that decisions regarding his care, treatment and any investigations or assessments are effectively being made under the provision of best interest decisions.

32.3 If a care plan can be reviewed to create a restriction of liberty rather than the proposed DoL then this should be done. Advice is available from the Trust Legal Services. If the care plan needs to be delivered in a such a restrictive way and the person meets the criteria for detention under the MHA then a MHA assessment must be organised in order to provide the person with the opportunity to access the safeguards available under this Act and avoid an unlawful detention.

32.4 There are six criteria which must be met prior to any authorisation being granted by the appropriate Supervisory Body. They are;

1. **Age Assessment**; the person must be over the age of 18 years
2. **No Refusals Assessment**; there are no Advance Decisions refusing the treatment intended to be provided whilst the person is being deprived of his liberty nor any Donee or Deputy who has the authority to refuse such a treatment
3. **Mental Capacity Assessment**; the person must lack capacity to consent to being in the place where the proposed care and treatment are to be given.

4. **Mental Health Assessment**; the person has a mental disorder within the meaning of the MHA, but including learning disabilities
5. **Eligibility Assessment**; does the person meet the criteria for an application under the MHA. Note this does not mean that the person must be detained under the MHA, but that he meets the minimum criteria for detention under the MHA.
6. **Best Interest Assessment**; that it is in the person's best interests to be deprived of his liberty in this environment for the purpose of providing care or treatment.

32.5 The above assessments are conducted by a minimum of two assessors who are; the Mental Health Assessor and the Best Interest Assessor. They are appointed by the Supervisory Body and have in the case of an Urgent Authorisation 7 calendar days to complete all six assessments and the reports and the recommendations to the Supervisory Body Panel for authorisation or refusal of the DoL application, or in the case of a Standard Authorisation, 21 calendar days.

32.6 When a care team consider that they may have a DoL and that they are unable to avoid this level of care plan then the Dr in charge of treatment Consultant Psychiatrist should contact the local MHA/MCA office for the appropriate DoL application form. In the case of a planned DoL then a standard authorisation will be required (form 4), in the case of an urgent authorisation both an urgent and a standard authorisation request will need to be submitted (forms 1 and 4). The form(s) will need to be completed by the team and returned promptly to the MHA/MCA office who will submit the form(s) to the appropriate Supervisory Body. Assistance in the decision making and completion of the form is available from Legal Services.

32.7 The appointed assessors will contact the ward and arrange to attend to meet with the person and members of staff to complete their assessments. Staff must provide the assessors with information to assist the assessment process, this includes access to appropriate medical and RiO records and any relevant recent assessments. This does not permit full access to all of the person's records, only those that are relevant to the assessment process.

32.8 The Ward and the MHA/MCA Office will be notified of the decision of the Supervisory Body. Once the person is subject to a DoL authorisation he is known as the Relevant Person. This will include the duration of the authorisation (up to 12 months), any conditions which are attached to the authorisation and the name of the Relevant Persons Representative.

32.9 It is the responsibility of the ward staff to give the patient who is now subject to the DoL authorisation;

1. A copy of the authorisation form to the Relevant Person and any IMCA instructed for that person
2. Do everything practicable to explain to the Relevant Person both orally and in writing what the effect of the authorisation is
3. The Relevant Person's right to apply to the Court of Protection for it to be terminated
4. Inform Relevant Persons family, friends and carers about the authorisation so that they can support the Relevant Person this may be done in person, by telephone , e mail or letter
5. Record in RiO the steps taken to involve the Relevant Person's family, friends and carers and anyone else with an interest together with their views and with details of any IMCA who has been instructed

32.10 The ward or unit must keep a record of the involvement of the Relevant Persons Representative including their visits to see the patient (known as the Relevant Person), attendance at ward rounds and inclusion in the care planning.

32.11 The MHA office will notify the Consultant Psychiatrist one month before the DoL authorisation is due to expire. The care team must then determine if a further period of DoL authorisation is required. The MHA/MCA office must be notified of the decision to ensure that the appropriate forms are supplied to the care team for completion. These forms must be returned to the MHA/MCA Office for submission to the relevant Supervisory Body. Assistance with this process is available from Legal Services.

32.12 The authorisation will only have relevance for the ward for which it has been provided. Its authority is non-transferable. In the event that the person needs to be moved, e.g. a transfer to the acute trust or move to another unit the MHA/MCA office must be notified immediately and the Supervisory body informed to enable suspension of the authorisation and lawful care plan.

32.13 Procedure can be located http://nww.swyt.nhs.uk Mental capacity act

33.0 Training and Compliance with this policy

Training will be made available to staff through sessional training, specific groups of practitioners and on ad hoc basis relating to specific issues. Specialist advisors where applicable will and do incorporate within training programmes specific elements of the Mental Capacity Act.

Information is available in the form of leaflets for patients, carers and staff and are accessible on the Trust website and the department of constitutional affairs.

Compliance with this policy will be through review of incidents and audit within each two year period from approval of this policy

Definitions

Code of Practice	The Mental Capacity Act Code of Practice 2015

34.0 Duties

34.1 Trust Board is responsible for approving the policy for the approval of this policy.

34.2 The Lead Director is responsible for ensuring that the policy has been developed in line with the trust policy for the development, approval and dissemination of policy and procedural documents.

34.3 General managers, clinical leads and team managers are responsible for ensuring that staff in their area of responsibility are aware of their responsibilities under the policy and that they follow the policy.

34.4 Medical, nursing and other clinical staff are responsible for ensuring that their actions comply with the policy.

34.5 Mental Health Act Office staff are responsible for advising on the practice related to the policy insofar as it is governed by the Mental Capacity Act 2005.

35.0 Principles

This policy seeks to describe the trust's duties under the Mental Capacity Act, ensuring that all patients are involved in decisions about their care to their maximum ability, or where they lack capacity to be involved in decision making about their care there are legal safeguards in place.

36.0 Equality impact assessment

The policy has had an equality impact assessment, (appendix A).

37.0 Dissemination and implementation arrangements

The policy will be disseminated through the trust information channels and through professional groups. It will be placed on the trust intranet.

38.0 Process for monitoring compliance and effectiveness

Compliance with the MCA, including the completion of capacity assessments where required will be monitored by clinical services on a daily basis. More significant capacity decisions will be monitored by senior clinical staff with advice from the Mental Health Act Office

39.0 Review and revision arrangements

The policy will be reviewed by the Assistant Director, Legal Services on behalf of the accountable director by the review date, or earlier if required. Previous copies will be archived in line with trust procedures.

40.0 References

Department of Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice TSO London

Mental Capacity Act 2005

Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice TSO London

41.0 Associated Documents

Department of Health (2015) Mental Health Act 1983: Code of Practice TSO London

Mental Health Act 1983

Safeguarding adults at risk of abuse or neglect policy

Safeguarding and promoting the welfare of children policy

Appendix A

Equality Impact Assessment and Action Plan

EIA

EIA action plan

Appendix B

Checklist for the Review and Approval of Procedural Document

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	NO	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	NO	Technical interpretation of law
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	YES	MCA training is already in place
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	NO	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix C

Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	December 2008			
2	October 2010	Head of Legal Services	DRAFT	
3	February 2016	Assistant Director, legal services	Reviewed	None