NHS
Nottingham and Nottinghamshire
Integrated Care Board

Mental Capacity Act 2005 Policy

July 2023 - July 2026

CONTROL RECORD				
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			Sponsor Director of Nursing	
			Team Safeguarding	
Title	Mental Capacity Act 2005 Policy			
Amendments	Insertion of paragraph 1.7 - The Mental Capacity (amendment) Act 2019			
Purpose	The purpose of this policy is to outline the use and remit of the Mental Capacity Act to staff working in or with Nottingham and Nottinghamshire Integrated Care Board (ICB), who may have their			
Superseded Documents	Mental Capacity Act 2005 Policy v1.1			
Audience	All employees of the Nottingham and Nottinghamshire ICB (including those working within the organisation in a temporary capacity)			
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1. Introduction

1.1. This policy applies to Nottingham and Nottinghamshire Integrated Care Board, hereafter referred to as 'the ICB'.

1.2. The Mental Capacity Act (2005) (the Act) came into force in October 2007 and for the first time it provided a legal framework for acting and making decisions on behalf of vulnerable people who lack the mental capacity to make specific decisions for themselves. The Act provides a statutory framework to empower and protect such individuals. It makes it clear who can take decisions, in which situations and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity.

1.3 In order to protect the rights of vulnerable individuals who for their own safety need to be accommodated under care and treatment regimes that could deprive them of their liberty, the Government has added provisions to the Act. The Deprivation of Liberty Safeguards (DoLS) ensure that any decision taken to deprive someone of their liberty is made in accordance with well-defined processes, thoroughly documented and carried out in consultation with specific authorities.

1.4 The Act also aims to ensure that any decision made or action taken on behalf of an individual, who lacks the capacity to make that decision themselves, will always be made in their best interests. However, there are certain decisions that can never be made on behalf of a person lacking capacity because they have been specifically excluded from the provisions of the Mental Capacity Act. These are:

- Decisions concerning family relationships;
- Mental Health Act matters;
- Voting rights;
- Unlawful killing or assisting suicide.

1.5 This policy explains the key provisions of the Act and identifies the steps that relevant staff in the Health and Social Care Community should take when issues about an individual's capacity to make decisions arise. This document will be reviewed frequently in order to take account of amendments stemming from:

- The Mental Health Act 1983 and case law associated with it;
- Case law resulting in changes in the interpretation and use of the Mental Capacity Act;
- Data Protection Act 2018;
- Human Rights Act 1998;
- The Children Act 1989 and 2004;
- The Human Tissue Act 1998;

- The Deprivation of Liberty Safeguards 2008;
- The Care Act 2014;
- The Supreme Court Ruling: The Acid Test 2014;
- NHS England Safeguarding Accountable Framework 2015.

1.6 There are five key principles underpinning the Act:

1) A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2) The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3) That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
4) Best interests – anything done for or on behalf of people without capacity must be in their best interests.
5) Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

1.7 The Mental Capacity (amendment) Act 2019, the purpose of which was to reform the DoLS process under the Mental Capacity Act 2005 ("MCA"). However, the new process known as the Liberty Protection Safeguards has been postponed for the life-time of this current Parliament and plans for implementation of the amendment are yet to be decided.

2. Purpose

2.1 The purpose of this policy is to provide staff working in or with Nottingham & Nottinghamshire ICB who may have their own policy with a guide to the Mental Capacity Act 2005. It sets out the main provisions of the Act, identifies the duties placed on health and social care staff and provides a procedure to determine the circumstances in which the various processes described within the Mental Capacity Act should be followed.

2.2 This guidance supplements and should be used in conjunction with the Mental Capacity Act 2005 guidance. The ICB is committed to ensuring that all people using our commissioned services are treated with dignity, respect and individuals and their families/carers receive appropriate care and support.

2.3 This policy is not a replacement for the Mental Capacity Act Code of Practice (2007) or the Deprivation of Liberty Safeguards Code of Practice (2008), which serves as

an addendum to the Mental Capacity Act Code of Practice which should be consulted to guide on good practice.

2.4 **Definitions:**

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

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

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

2.4.4 **Decision-maker** under the Act, many people may be required to make decisions or act on the behalf of someone who lacks capacity to make decisions for them. The person making the decision is referred to as the decision-maker and **it is the decision-maker’s responsibility to work out what would be in the best interest** of the person who lacks capacity.

2.4.5 **Restraint** is using force or threatening to do so, in order to stop someone doing something they are resisting. It is also defined as restricting a person’s freedom of movement, whether they are resisting or not. The appropriate use of restraint always falls short of depriving a person of their liberty

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

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

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

2.4.9 **Court Appointed Deputy** is someone who has been appointed by the Court of Protection to make decisions on behalf of an individual who lacks capacity.

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

3. Scope

3.1 This policy applies to everyone in a paid, professional or voluntary capacity who is involved in the care, treatment or support of people aged 16 years or over under the umbrella of Nottingham & Nottinghamshire ICB. This includes staff employed by the ICB who are either seconded to the ICB or work in partnership with the ICB and volunteers who are working within the ICB.

3.2 **People Covered by the Mental Capacity Act (MCA)**

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

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

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A Learning Disability;
- Physical or mental conditions leading to confusion, drowsiness or loss of consciousness including delirium, concussion, and the long-term effects of brain damage; or
- The symptoms of alcohol or drug use.

3.2.3 Due to this impairment of mind or brain, the person is unable to do one or more of the following:

- Understand information given to them;
- Retain that information long enough to be able to make the decision;
- Weigh up the information available to make the decision; and
- Communicate their decision - this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

3.2.4 It is crucial that when assessing someone's capacity that you identify and are clear as to what decision you are assessing their capacity against. However, it is important to know that having a particular diagnosis or disability should not of itself be taken as an indication that the person does or does not lack capacity. As stated in the five key principals of the Act, all individuals must be presumed to have capacity, unless it is established otherwise under the two-stage capacity test set out in the Act and described in more detail in Section 5.1.

3.3 Younger People

3.3.1 The MCA applies to children from their 16th birthday who may lack the Mental Capacity as defined in the MCA to make their own decisions. Most of the provisions of the Act apply to young people of 16 and 17 years old. Decisions relating to treatment of young people of 16 and 17 who lack capacity must be made in their best interests in accordance with the principles of the Act. Parental responsibility (PR) should be taken into account up to the age of 18 years along with consultation with their family and friends where practicable and appropriate.

3.3.2 The Children Act 1989 covers the care and welfare of children in most situations. The Mental Capacity Act applies to children under 16 years in two ways:

- The Court of Protection can make decisions about the property and affairs of a child where it is likely that the child will lack capacity to make those decisions when they reach 16 years old.
- The criminal offence of ill treatment or neglect applies to children who lack capacity.
- Court of Protection can make decisions about a younger child's property / finances (or appoint a deputy) if it is likely that the child will still lack capacity when they reach 18 years.

3.4 Mental Health Act 1983

3.4.1 If a person is detained under the Mental Health Act (MHA) 1983, the Mental Capacity Act (MCA) 2005 does not apply to treatment for the person's mental disorder. Therefore, advance decisions and Lasting Power of Attorneys are not binding and deputies cannot consent or refuse treatment for mental disorder given under the MHA 1983, these should none the less be taken into account when making treatment choices. However, the MCA 2005 does apply to treatment for a condition or illness other than mental disorder for a patient detained under the MHA 1983 e.g., physical health needs.

3.5 Testing the capacity of patients detained under the Mental Health Act

3.5.1 This is required where it is specified in the MHA 1983 in connection with treatment.

3.6 Compliance with the Mental Health Act 1983 and Human Rights Act

3.6.1 To ensure compliance with the MH Act 1983 and Human Rights Act 1998 in regard to the right to tribunals:

- For all newly detained patients, where their mental capacity to be able to apply to the Mental Health Review Tribunal must be assessed. If the patient does not have capacity, consideration must be given to their wishes and if appropriate, assistance provided to facilitate a Tribunal Hearing (whether this is through the nearest Relative or the Secretary of State).
- Keep under review the mental capacity of all detained patients.
- Ensure compliance with Section 132, providing information to patients and Nearest Relatives about their statutory rights.

4. Roles and Responsibilities

4.1 Below is stated the key responsibilities for specific roles and staff groups in relation to delivering the documents objectives:

Role	Responsibilities
Chief Executive	The Chief Executive has responsibility for meeting all statutory requirements and for implementing guidance issued by the Department of Health in respect of MCA legislation and ensuring it is implemented across commissioning services.

Role	Responsibilities
Director of Nursing	The Director of Nursing has senior responsibility for overseeing the implementation of the MCA which is delegated to the Designated Professional for Safeguarding Adults as the Lead Officer.
Designated Professional for Safeguarding Adults	The Designated Professional for Safeguarding Adults is the lead for the Mental Capacity Act and Deprivation of Liberty Safeguards. This role provides guidance and support to staff when implementing the provisions of the act. The Designated professional for Safeguarding Adults will interpret and advise on any new guidance and seek assurance from providers about their compliance.
MCA Lead	The Designated Professional for Safeguarding Adults as the MCA Lead must: • Ensure that best practice around mental capacity is promoted, implemented and monitored both within the ICB and within commissioned provider services. • Ensure that safeguarding and MCA leads work within the local health and social care economies to influence local thinking and practice around MCA. • Ensure that learning from cases where mental capacity has been an issue will be used to inform future commissioning and practice. • Ensure the provider contacts specify compliance with MCA and DoLS legislation and that commissioned services are supported and contract monitored for compliance with MCA. • Work with local agencies to provide joint strategic leadership on MCA and DoLS in partnership with Local Authorities, provider clinical governance teams and safeguarding leads, CQC, and where applicable, the police. • Engage with local Safeguarding Adults Board and Board sub-Groups.
ICB Staff	All staff are responsible for having an awareness of the policy and how it may apply to them in their role. Staff working in a clinical capacity must adhere to the principals of the MCA in all aspects of their role.

Role	Responsibilities
Providers	Provider organisations are responsible for ensuring compliance with MCA legislation (including DoLS) within and across their organisation. • All providers must have a MCA Lead that is responsible for providing support and advice to Clinicians in individual cases and supervision for staff in areas where these issues may be particularly relevant and/or complex. • GP practices are required to have a lead for Safeguarding and MCA who should work closely with the Named GP and Designated Safeguarding Professional. They must ensure that there is clarity as to who holds corporate responsibility for MCA and DoLS functions within the organisation, and that appropriate governance and safeguarding systems are in place to deliver best practice. They must be in a position to provide assurance to the ICB that responsibilities with respect to MCA are being safely discharged.

5. Procedure/Implementation

5.1 Conducting Assessments of Capacity

5.1.1 Under the Mental Capacity Act, a decision about one person's capacity can be made by **anyone** who follows the assessing criteria – **it is no longer the specific responsibility of a psychiatrist or other doctor.** This will usually be the person most directly connected with the individual at the time the decision has to be made. This will particularly be the case for day-to-day decisions.

5.1.2 For more complex decisions, relating to care or treatment, it may be appropriate that the decision may be taken by a health or social care professional. **Professional involvement might be needed if:**

- The decision that needs to be made is complex or has serious consequences;
- An assessor concludes that a person lacks capacity, but the person wishes to challenge that decision;
- Family, carers and/or professionals disagree about a person's capacity;

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

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

5.1.4 **General issues:** Mental capacity is the ability to make a decision, ranging from a minor decision that affects daily life only, to a more significant decision with much wider implications, including a decision that may have legal consequences for themselves or others. The starting point is always to assume that a person has capacity to make a specific decision, although possibly with help or support.

5.1.5 In order to determine whether a person lacks capacity to make a particular decision, the Act precisely defines what is meant by 'lack of capacity' and 'inability to make a decision'.

5.1.6 There are two basic questions that staff need to consider:

Stage 1 - Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

- If 'No', the person cannot be assessed as lacking capacity.
- If 'Yes', proceed to stage two.

Stage 2 - Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

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

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

- **Retain that information** – the fact that the person is only able to retain the information for a short period of time does not prevent him/her from being able to make a decision.
- **Use and weigh up the information** - as part of the process of making that decision. It is not enough to just understand and retain the information the person needs to be able to consider the consequences of the decision.
- **Be able to communicate that decision** – all attempts should be made to enable a person to communicate their decision, this may include, visual aids, non-verbal gestures etc. A complete inability to communicate is rare However, in these circumstances the Act is clear that a person should be treated as if they are unable to make a decision.

‘NO’ to any one of the above will constitute a lack of capacity to make a particular decision

5.1.8 Appendix B gives an overview of the process to follow when a vulnerable person’s capacity is in question.

5.1.9 In order to document and structure this process in a formal and clear way, there is an example of a Pro-forma which could be used for assessing and documenting Mental Capacity (Appendix B). This type of pro-forma enables those staff and other individuals involved in carrying out such an assessment, to assemble all of the information they require in a way that clearly shows how they have justified their conclusions. Agencies outside of the Nottingham & Nottinghamshire ICB may have their own pro-forma for assessing and documenting Mental Capacity.

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

- A person's capacity must be assessed specifically in relation to their capacity to make a particular decision at the time it needs to be made;
- A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour;
- It is important to take all possible steps to try to help people make a decision for themselves, e.g.:
    - Would the person have a better understanding if information was explained or presented in another way?
    - Are there times of day when the person's understanding is better?
    - Are there locations where they may feel more at ease?

- Can anyone help the person to express a view or make a choice, e.g. a family member or carer or someone to help with communication?

5.2 Best Interests

5.2.1 Everything that is done for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which must be considered by the decision-maker. Also, carers and family members have a right to be consulted. In order to document and structure this process in a formal and clear way, an example of a pro-forma which may be used as a best interest checklist (Form MCA 2) as a means of ensuring that all the statutory requirements are covered (see Appendix D). Agencies outside of the Nottingham & Nottinghamshire ICB may have their own pro-forma for assessing and documenting Mental Capacity.

The Decision Maker Checklist - key points:

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

Find out the person's views - consider, insofar as can reasonably be ascertained:

- The person's past and present wishes and feelings, which may have been expressed verbally, in writing or through behaviour or habits (including any written preferences/wishes set out in an advanced statement.
- Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
- Any other factor is the person themselves would be likely to consider if they were making the decision themselves.

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, feelings, beliefs and values. In particular, try to consult:

- Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues.
- Anyone engaged in caring for the person.
- Close relatives, friends or others who take an interest in the person's welfare.
- Any Attorney appointed under a Lasting Power of Attorney made by the person.
- Any Deputy appointed by the Courts of Protection to make decisions for the person.

- For decisions about serious medical treatment where there is no one to consult who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

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

- **Avoid discrimination** - do not make assumptions about somebody's best interest simply on the basis of their age, appearance, condition or behaviour.
- **Assess whether the person might regain capacity** – consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- **If the decision concerns life sustaining treatment -** the decision must not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

5.3 Acts in Connection with Care and Treatment

5.3.1 Where care or treatment is provided for someone who lacks capacity, that care (including any actions that would normally require consent such as assistance with bathing and dressing, as well as providing medical treatment) can only be provided without incurring civil or criminal liability where the ‘ decision-makers’ take reasonable steps to establish whether the person lacks capacity in relation to the matter in question and when giving care/treatment, the decision maker reasonably believes that the person lacks capacity and that it will be in the person's best interest for the care/treatment to be provided.

5.3.2 The Act defines restraint as any restriction of liberty of movement (whether or not the person resists) or the use or threat of force where an incapacitated person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the individual in question and the restraint used is proportionate to the likelihood and seriousness of the harm.

5.3.3 Depriving a person of his or her liberty is still subject to the meaning of Article 5(1) of the European Convention on Human Rights. Therefore, if staff are concerned that a service user is or might be deprived of their liberty they should refer the case to the Managing Authority.

5.4 Advance Decision

5.4.1 The Act has created statutory rules with clear safeguards so that individuals can make decisions in advance to refuse treatment if they should ever lack capacity. The decision must be made by a person who is 18 years or over at the time when the person has capacity to make it and it must specify the treatment to be refused. This advance decision may be withdrawn by the person at any time by any means.

5.4.2 If there is any doubt as to the validity or applicability of the advance decision then it should be referred to the Court of Protection for the Court to decide.

5.5 Excluded Decisions

5.5.1 Section 27 of the Mental Capacity Act lists certain decision that can never be made on behalf of a person who lacks capacity. These include:

Family Relationships:

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

Mental Health Act - Nothing in the Act authorises anyone:

5.5.2 To consent to a patient being given medical treatment for a mental disorder if, at the time when it is proposed to treat the patient, the treatment is regulated by Part 4 of the Mental Health Act 1983.

5.5.3 There will be no question of an attorney consenting or of the Court of Protection making an order or appointing a deputy to provide consent.

5.6 Ill Treatment or Wilful Neglect: A Criminal Offence

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

5.7 Payment for Goods and Services

5.7.1 Staff should be aware that previous legislation and common law rules have now been brought together by the Mental Capacity Act regarding a person lacking capacity and the purchase of 'necessaries' in terms of goods and services. The Mental Capacity Act makes it clear that a person lacking capacity must pay a 'reasonable price' for goods and services supplied to them. A person who is acting under Section 5 Mental Capacity Act may

arrange something for a person's care or treatment and promise that the person receiving the care and/or treatment will pay for it. This is restating the common law rules which provide that a person acting as an 'agent of necessity' should not be out of pocket for acting in good faith.

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

5.8 Research

5.8.1 The Mental Capacity Act in Sections 30, 31, 32, 33 and 34 lays down clear parameters for research where people without capacity may be the subjects. The provisions contained in the Mental Capacity Act are based on long-standing international standards e.g. World Medical Association. The appropriate authority must be sought prior to launching a research project i.e. the Secretary of State in England.

5.9 Independent Mental Capacity Advocate

5.9.1 The role of the Independent Mental Capacity Advocates (IMCA) is to support and represent individuals who lack capacity. Where the incapacitated person has no one to support them (other than paid staff) an IMCA must be instructed, and then consulted, whenever:

- An NHS body is proposing to provide serious medical treatment; or
- An NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital (where the hospital stay will be longer than 28 days) or a care home (where the care home stay will be more than a weeks).
- An IMCA may be in structure to support someone who lacks capacity to make decisions concerning: Care reviews, where no one else is available to be consulted
- Adult protection cases, whether or not to family, friends or others are involved.

5.9.2 The IMCA's role is to support the person who lacks capacity and to represent their views and interests to the decision-maker. IMCAs therefore have the right to see relevant health care and social care records. Any information or reports provided by an IMCA must be taken into account as part of the process of deciding whether a proposed decision is in the incapacitated person's best interest.

5.9.3 The IMCA's role will include interviewing the person who lacks capacity, if possible, as well as examining relevant health and social care records, plus obtaining the views of professionals providing care or treatment for the

person who lacks capacity and obtaining the views of anyone else who can give information about the wishes, feelings, beliefs or values of the person who lack capacity. The IMCA should also consider whether obtaining another medical opinion would help the person who lacks capacity and must write a report on their findings for the NHS body or Local Authority concerned.

5.9.4 If staff believe it may be necessary to involve an IMCA in a particular case, this should be discussed with their line manager.

5.10 Lasting Power of Attorneys (LPAs)

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

5.10.2 Lasting Powers of Attorney can cover two different types of decision making:

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

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

- Be a written document set out in the form required by the Mental Capacity Act.
- Must be registered with the Office of Public Guardian (OPG) before it can be used. An unregistered LPA will not give the Attorney any legal powers to make a decision for the Donor. The Donor can register the LPA whilst they are still capable, or the Attorney can apply.
- To register the LPA at any time.

5.10.3 Personal welfare LPAs can include decisions about where the Donor should live and who they should live with, there day to day care and consenting to/refusing medical treatment on the Donors behalf. Donors can add restrictions or conditions to areas where they would not wish the Attorney to have power to act.

5.10.4 Attorneys are always required to follow the principles in the Mental Capacity Act and must make decisions in the Donor's best interests.

5.10.5 Importantly, the decisions of an attorney about whether to consent to or refuse medical treatment will 'trump' that of the incapacitated person's

clinical team. However, if healthcare staff disagree with the Attorney's assessment of interest, they should consider obtaining a second opinion and should then discuss the matter further with the Attorney. If the disagreement cannot be settled, an application can be made to the Courts of Protection which can decide where the individual's best interests lie. Whilst an application is being made to the Court of Protection, healthcare staff can give life sustaining treatment to prolong the Donor's life or to stop their condition getting worse.

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

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

5.11 Court-Appointed Deputies

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

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

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

5.12 Court of Protection

5.12.1 The Court of Protection is a specialist court, set up under the Mental Capacity Act, to deal with issues relating to decision making on behalf of people who lack capacity.

5.12.2 The powers of the Court of Protection include:

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

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

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

5.12.5 Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from patients in a permanent vegetative state:

- Cases involving organ or bone marrow donation by a person who lacks capacity.
- Cases involving proposed non-therapeutic sterilisation of a person who lacks capacity (e.g. for contraceptive purposes).

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

- Obtaining an independent second opinion.
- Holding a case conference involving staff and family members.

6. Equality and Diversity Statement

6.1. Nottingham and Nottinghamshire ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation as a commissioner and provider of services, as well as an employer.

6.2. The ICB is committed to ensuring that the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary), marriage or

civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

6.3. We are committed to ensuring that our activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, Roma and travellers.

6.4. As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

6.5. To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed and is attached to this policy at Appendix A.

7. Communication, Monitoring and Review

7.1. This policy will be communicated to staff via the ICB's Website and Intranet pages.

7.2. This policy will be reviewed every three years unless national guidance, legislation or good practice changes during that period of time and will be approved by the ICB's Quality and People Committee.

7.3. Any individual who has queries regarding the content of this policy, or has difficulty understanding how this policy relates to their role, should contact the document author.

8. Staff Training

8.1. Training will be provided for relevant Nottingham and Nottinghamshire ICB staff on the Mental Capacity Act to ensure that staff are adhering to the Act and also have the most up-to-date knowledge in this area.

9. Interaction with other Policies

9.1. Other documents that this policy should be read in conjunction with are:

- Deprivation of Liberty Safeguards Policy;
- Safeguarding Policies.

10. References

10.1. The Mental Capacity Act 2005 applies in conjunction with other legislation, under which health and social care staff have obligations relating to people who lack capacity, including:

- Browne Jacobson MCA (presentation September 2017);
- Data Protection Act 2018;
- Human Rights Act 1998;
- Human Tissue Act 2004;
- Mental Capacity Act 2005;
- Mental Capacity Act Code of Practice;
- Mental Health Act 1983 (as amended by the Mental Health Act 2007);
- National Health Service and Community Care Act 1990;
- NHS England Safeguarding Adult Guide
- The Care Act 2014;
- The Children's Act 1989;
- The Deprivation of Liberty Safeguards 2008.

Appendix A: Equality Impact Assessment

Overall Impact on: **Equality, Inclusion and Human Rights** **[Select one option]**	**Positive ☐ Neutral ☒** **Negative ☐ Undetermined ☐**

Name of Policy, Process, Strategy or Service Change	Mental Capacity Act 2005 Policy	**Date of Completion**	July 2023
EIA Responsible Person Include name, job role and contact details.	Ishbel Macleod, Designated Professional for Safeguarding Adults Email: Ishbel.macleod@nhs.net		
EIA Group Include the name and position of all members of the EIA Group.			
Wider Consultation Undertaken State who, outside of the project team, has been consulted around the EIA.	None		
Summary of Evidence Provide an overview of any evidence (both internal and external) that you utilised to formulate the EIA. E.g., other policies, Acts, patient feedback, etc.	Equality Act 2010; Mental Health Act; Mental Capacity Act 2005; Human Rights Act 1998.		

	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?	What, if any**, additional actions should be considered** to ensure the policy, process, strategy or service change is as inclusive as possible? Include the **name and contact details** of the person responsible for the actions.	**Impact Score**
Age	The policy is likely to have a positive impact on the characteristic of Age. The Policy clearly sets out the requirements around the Mental Capacity Act 2005, and DoLS 2010 for young people and adults aged 16 years and over.	There is no actual or expected negative impact on the characteristic of Age.	None.	None.	4
Disability[1] (Including: mental, physical, learning, intellectual and neurodivergent)	The policy is like to have a positive impact on the characteristic of Disability. The Policy is designed to safeguard people who lack capacity, often through a disability,	There is no actual or expected negative impact on the characteristic of Disability.	None.	None.	4

	either permanently or temporarily. The Policy clearly outlines the processes and steps to assessing and deciding if someone lacks capacity.				
Gender[2] (Including: trans*, nonbinary and gender reassignment)	There are no actual or expected positive impacts on the characteristic of Gender.	There is no actual or expected negative impact on the characteristic of Gender.	None.	None.	3
Marriage and Civil Partnership	There are no actual or expected positive impacts on the characteristic of Marriage and Civil Partnership.	There is no actual or expected negative impact on the characteristic of Marriage and Civil Partnership.	None.	None.	3
Pregnancy and Maternity Status	There are no actual or expected positive impacts on the Pregnancy and Maternity Status characteristic.	There is no actual or expected negative impact on the characteristic of Pregnancy and Maternity.	None.	None.	3
Race[3]	There are no actual or expected positive impacts on the characteristic of Race.	There is no actual or expected negative impact on the characteristic of Race.	None.	None.	3

Religion and Belief[4]	There are no actual or expected positive impacts on the characteristic of Religion or Belief.	There is no actual or expected negative impact on the characteristic of Religion and Belief.	None.	None.	3
Sex[5]	There are no actual or expected positive impacts on the characteristic of Sex.	There is no actual or expected negative impact on the characteristic of Sex.	None.	None.	3
Sexual Orientation[6]	There are no actual or expected positive impacts on the characteristic of Sexual Orientation.	There is no actual or expected negative impact on the characteristic of Sexual Orientation.	None.	None.	3
Human Rights[7]	The Policy is expected to have a positive impact on Human Rights. The Policy clearly outlines the steps in place to protect people's rights when they lack the capacity to make a specific decision. The Policy will promote Article 2, Article 5, and Article 8 in particular.	There is no actual or expected negative impact on Human Rights.	None.	None.	4

	The Policy also protects those that do have capacity to make a decision from being deemed not to have capacity. This will promote their rights under all the Articles and Protocols of the Human Rights Act 1998.				
Community Cohesion and **Social Inclusion**[8] (Including: personalised care)	There are no actual or expected positive impacts on the characteristic of Community Cohesion and Social Inclusion.	There is no actual or expected negative impact on Community Cohesion and Social Inclusion.	None.	None.	3
Safeguarding[9] (Including: adults, children, LAC and adults at risk or who lack capacity)	The Policy is expected to have a positive impact on safeguarding. The Policy is designed to ensure that people who lack capacity are safeguarded from abuse, and that decisions are made in their best interests, and in line with the Mental Capacity Act, DoLS, and the Mental Health Act.	There is no actual or expected negative impact on Safeguarding.	None.	None.	4

Other Groups at Risk[10] of Stigmatisation, Discrimination or Disadvantage	There are no actual or expected positive impacts on 'Other Groups at Risk'.	There is no actual or expected negative impact on 'Other Groups at Risk'.	None.	None.	3

Additional Narrative
 	
Provide additional evidence and narrative about the positive, negative, and neutral impacts of the proposal on the equality, inclusion and human rights elements detailed above.
 	
You should consider:
• Three elements of Quality (safety, experience and effectiveness)
• Intersectionality
• Impact of COVID-19
• Access to Services
  ○ Physical
  ○ Written communication
  ○ Verbal communication
• Digital Poverty
• Safeguarding
• Dignity and Respect
• Person-centred Care
	Overall, this Policy will have a positive impact around Safeguarding, Disability, and Human Rights. It will support people who lack capacity to be treated with respect and dignity. For those with capacity, it ensures they are free to make an informed decision about their health, care, wellbeing, finances, and other aspects of their lives.	3

Positive Impact	**Neutral Impact**	**Negative Impact**	**Undetermined Impact**	**Equality Impact Score Total**	46
56 to 50	**49 to 36**	**35 to 22**	**21 to 14**		

Positive	**Neutral**	**Negative**	**Undetermined**
4	**3**	**2**	**1**

1. **Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

2. **Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

3. **Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

4. **Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

5. **Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

6. **Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

7. The **Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

8. **Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

9. **Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

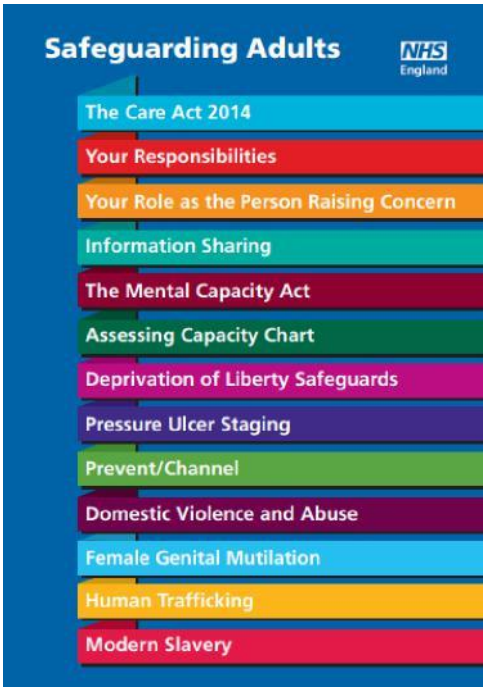
10. **Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).

Appendix B:

Mental Capacity Act 2005: Process Overview

The Mental Capacity Act process can be found in the NHS England Safeguarding Adult Guide (see picture below). Click on the link below to take you to the picture and the most current guide.

https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf



This guide provides the MCA principles, pathway of assessment and when and how to undertake a Best Interest Assessment.

Appendix C:

Mental Capacity Act 2005: Functional Test for Capacity

This test is designed for use by qualified clinicians and practitioners and must be included in the patient/service user record.

Patient/User

Name: ..... DOB: .....

Healthcare ID No: .....

PART 1: THE DIAGNOSTIC THRESHOLD

The Act requires the assessor to have "reasonable belief" that a person lacks capacity in relation to a decision. The Act and the Code of Practice acknowledge that if there is an established diagnosis of mental illness, learning disability or some other condition then this is sufficient to confirm "an impairment or disturbance of the mind". Practitioners need to take all reasonable steps to satisfy themselves that there is a temporary or permanent impairment or disturbance in the functioning of the mind or brain. Healthcare staff will usually ascertain this from the diagnostic information available.

Does the patient/service user have an impairment of or disturbance in the functioning of the mind or brain? YES/NO

If the answer is NO then capacity is not an issue. If YES then record the nature of the disturbance:

Neurological Disorder:	
Learning Disability:	
Mental Disorder:	
Dementia:	
Stroke:	
Head Injury:	
Delirium / Unconsciousness:	
Substance Use	
Other: Please specify:	

Nature of the specific decision

Record in the space below the **specific decision** which the person needs to make:

PART 2: THE FUNCTIONAL TEST:

1) Does the person understand the information relevant to the decision?
YES/NO

Reasons for decision:

2) Can the person retain the information for long enough for the decision to be made?
YES/NO

Reasons for decision:

3) Can the person use or weigh the information to make a choice?
YES/NO?

Reasons for decision:

4) Can the person communicate their decision in any way?
YES/NO

Reasons for decision:

Answering NO to any part indicates lack of capacity in relation to this specific decision.

Name and Job Title of Decision Maker

Name: .....Job Title: .....

Date and Time of Assessment

Date: .....Time: .....

Guidelines to the Functional Test - Understanding the information:
This test requires the assessor to help the person understand the information relevant to the decision. The Code of Practice provides examples. Information should be presented in a clear and simple way or with the use of visual aids. Cultural/linguistic considerations should be included and family, friends and carers of the person being assessed should be used to assist the process. In order to demonstrate "understanding" a person needs to understand the nature of the decision, the reason why it is needed and to have an element of foresight about the likely effects of making or not making the decision.

Retain the information:
Information need only be held in the mind of the person long enough to make the decision. The Code of Practice gives examples of how to help people retain information longer.

Use or weigh the information:
Some people can retain and understand the information but an impairment stops them using it. The inability to use the information has to be the result of the disorder not a lack of agreement with or trust in the decision-makers. The person must be able to consider and balance the arguments for and against a proposed action and weigh up the likely consequences before making a decision.

Communicate the decision:
The Code of Practice gives examples of how people should be helped to communicate "in any way". Assessors should consider using specialist workers to assist in communication.

General Notes:

- The answer NO to any question in Part 2 of the functional test indicates that the person lacks capacity in relation to that decision.
- The Act requires "reasonable belief" of the assessor that a person lacks capacity in relation to a decision.
- Clinicians/Practitioners need to be able to identify objective reasons why a person lacks capacity.
- Clinicians/Practitioners should take care to sign and date the assessment and record the time by the 24-hour clock.
- Remember that clinicians/practitioners must have regard to the Code of Practice when making decisions for people who lack capacity.

Appendix D:

Mental Capacity Act 2005: Evidence of Best Interests Consideration

This document is for use by a decision maker who is responsible for undertaking an act in connection with care or treatment for the person named below.

Name of Patient/Service User

Name: …… DOB: ……

Healthcare ID No: ..... ……..

THE SPECIFIC DECISION

Record in the space below the *specific decision* for which the person lacks capacity:

Essential Information

Has an "advance decision" been made about the decision in question (only in relation to a refusal of medical treatment) and is it valid & applicable?
YES/NO

Has the lead clinician been informed? Who has a copy? Is there a clear plan of what to do should the circumstances arise? (If yes then no further best interests assessment is necessary. MCA Code Chapter 9 MHA Code chapter 17).

Is there a Lasting Power of Attorney or Deputy in place with authority relating to this specific decision? YES/NO

If yes, is the LPA is registered with the Office of the Public Guardian? Make notes of the instructions received from the person who holds the appropriate authority as Power of Attorney or Deputy. If the Attorney or Deputy has the express power to make the decision, no further best interests assessment is necessary. MCA Code Chapter 7 and 8.

Have you considered whether it is likely that the person may have capacity at some time in the future and whether a delay in decision-making will allow them to make that decision themselves? YES/NO

If yes, describe plans to put off the decision. If no explain why the decision cannot be put off. MCA Code Chapter 5.

Patient/Service User involvement

Have you encouraged as far as is practicable that person's involvement in actions undertaken on their behalf or in any decisions affecting them? YES/NO

How have you encouraged the person's involvement? MCA Code Chapter 3 and 5?

Have you considered as much as is practicable the person's past and present wishes and preferences about the matter in question?

Have you considered any relevant written statement the person may have made when they did have capacity?

Have you considered the beliefs and values that would be likely to influence the person's attitude to the decision in question, i.e. religious, cultural and lifestyle choices?

Have you taken into account other factors that the person would be likely to consider in relation to the matter, i.e. emotional bonds, family obligations in deciding how to spend money or where to reside?

How have you done this? What evidence. Other evidence produced by the person? MCA Code Chapter 5 MHA Code Chapter 17.

Consultation

Have you consulted and taken into account the views of other key people as to what would be in the person's best interests? It is a legal requirement that an IMCA be commissioned if the decision concerns serious medical treatment (other than in an emergency or mental disorder treatment under the MHA) or change of accommodation over 28 days in hospital or 8 weeks in care home (but not if either is governed by the compulsory treatment provisions of the Mental Health Act) and the person has no family or others appropriate to consult. MCA Code Chapter 10.

Detail your consultation processes here:

Other Information

Have you considered alternative actions that produce less restriction on the person's rights and freedoms?

What alternatives have been considered? MCA Code Chapter 5.

Name of Patient/Service User

Name: …… DOB: ……

Healthcare ID No: ..... ……..

Name and Job Title of Decision Maker

Name: .....

Job Title: ……

Date of Best Interests Decision: .....

Appendix E:

Using the Mental Capacity Act to support patients with their activities of daily living

Surname: ..... **Date of Initial Assessment:** ……..

Forename: ..... **Assessing Ward:** ……....

Date of Birth: ..... **Assessing Nurse Name:** ……..

Hospital Number: :..... **Assessing Nurse Signature:** ……..

This care pathway is for adult patients (aged 18 and over) who are experiencing difficulties with decision making in relation to their personal care and treatment.

Mental Capacity means having the ability to make a decision.

Lack of Capacity means a person who lacks the mental ability to make a specific decision for himself at the time the decision needs to be made because of an impairment or disturbance in their brain or mind.

The following five Key principles of the Mental Capacity Act must be adhered to:

1) Assume every person has mental capacity unless it is proved otherwise.
2) A person is not to be treated as unable to make a decision until all practicable steps to help him to do so have been taken.
3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4) Anything done or any decision made on behalf of a person who lacks capacity must be done, or made, in their best interests.
5) Take the option which is less restrictive of the person's rights and freedom of action.

Where there are doubts about capacity
Doubts may arise about the patient's ability to make specific decisions because:

- Of their behaviour or circumstances;
- Of concerns raised by someone else;
- They are declining help or are resistive to care delivery / treatment;
- It has already been shown they lack capacity to make other decisions in their life.

Supporting Decision Making by the Patient
If you have doubts about the patient's ability to make decisions you should:

a) Ensure patient has the relevant information they need to make the decision, but don't overburden with more detail than required. Think, if it was me what information would I need to know?
b) Explain or present the decision in a way that is easier for the person to understand. Use appropriate communication aids as necessary e.g. interpretation, pictorial communication aids.
c) Break down difficult information into smaller points that are easy to understand.
d) Discuss the matter at times of the day or in places where the person will be most likely to understand.
e) Go through the consequences of making the decision or not - what are the risks or benefits?
f) Give balanced information about all the options where there is a choice to be made.
g) Ask someone to become involved who may be better able to help the person understand, for example a relative, friend, or carer who knows them well.
h) Where appropriate, avoid offering multiple choices, for example, if offering a drink, avoid offering lots of options; instead, only offer the person's favourite drinks.
i) If the person loses track of the conversation or has minor word finding difficulties then provide a gentle reminder of their last statement or suggest the word he/she might have wanted.
j) If the person appears to be nervous or worried, discuss his feelings with him where appropriate and offer reassurance.

ASSESSING MENTAL CAPACITY (See Insite Safeguarding Adults webpage for more information)

If you still have doubts then you must use the 2 stage test to assess the person's capacity to make a specific decision about care and treatment at the material time it is needed. The person who assesses capacity will usually be the person who is directly concerned with the individual at the time the decision needs to be made.

(For example, a HCA might need to assess if the person can agree to being washed or showered. A nurse might assess if the person can consent to pressure area care or to having medication).

Staff do not have to be experts in assessing capacity but should have a 'reasonable belief', on a balance of probability, that the person they care for lacks capacity to agree to the action or decision to be taken. Remember that a person may lack capacity to make a decision about one issue but not about others.

THE 2 STAGE TEST OF CAPACITY

1) Is there an impairment of, or a disturbance in, the person's mind or brain? (e.g., dementia, delirium, brain injury, hypoxia). If you cannot prove Stage 1 the patient will not lack capacity.

2) Does that impairment/disturbance mean that the patient is unable to make the particular decision at the time it is needed?

Can the person:

a) Understand the information relevant/salient to the specific decision;
b) Retain the information (for the time it takes to make a decision);
c) Use or weigh up that information in order to come to a clear conclusion;
d) Communicate their decision (by talking, sign language or any other means).

If the person cannot do 1 or more of the above then they will lack mental capacity, on a balance of probability. If the decision is complex then a formal assessment should be completed and recorded on a UHL mental capacity assessment form (available on Insite) and kept in the medical notes.

Best Interests Decision-Making

Once it is deemed that the person lacks mental capacity to make the specific decision(s) you must make a best interests decision, considering the factors below. Even the most simple day-to-day decisions need a best interest's decision to be made if we reasonably believe a person lacks the capacity to make them.

Best Interests Checklist

- Do whatever you can to involve the person in the decision, their views are still important.
- Think about a person's past and present wishes and feelings and the beliefs and values that would be likely to influence his decision if he had capacity (i.e. religious, cultural and moral beliefs and lifestyle choices).
- Wherever possible talk to others who know the person well.
- Find out all that you can that is relevant to the decision. What would be the impact of the decision on the person? What are the financial implications for the person? What are the potential benefits/burdens to the person?
- Take into account all of the things that the person who lacks capacity would if they were making the decision for themselves.
- Can the person regain capacity? If so, can the decision be delayed until that time?
- Take the less restrictive option / decision.
- Special considerations for life-sustaining treatment - All reasonable steps which are in the person's best interest should be taken to prolong life.
- Follow the checklist above and make a decision based on the patient's best interests.
- See the Safeguarding Adults Web pages for more information and advice - Mental Capacity Act - Social care and support guide - NHS (www.nhs.uk)

Appendix F:

Consent Form

PATIENT'S NAME: .....

NHS No: ..... DOB: .....

If you are the patient - please complete Section A
If you are not the patient- please complete Section B

SECTION A: For completion by the patient:
(patient with capacity)

I, the undersigned consent to

Name of patient: .....

Signed: ..... Date: .....

SECTION B: For completion by the patient's representative if the patient is incapable of completing Section A which has been assessed in accordance with the Mental Capacity Act 2005.

I, (name and relationship) .... confirm that the patient ..... is incapable of signing a consent form because the person lacks capacity (which has been assessed in accordance with the Mental Capacity Act 2005).

Signed: ..... Date: .....