



Mental Capacity Act (2005) Policy and Guidance

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1 Introduction

- 1.1** The underlying philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack capacity are the focus of any decisions being made, or actions taken on their behalf. This requires an individual approach that prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person. Staff should make every effort to ensure that that vulnerable people are helped to make as many decisions as possible for them self.
- 1.2** The MCA applies to everyone who works in health and social care and is involved in the care, treatment or support of people over the age of 16 and living in England and Wales, who are unable to make all or some decisions for them self. For young people aged 16 and 17¹, there is also a need to have regard to local Safeguarding Children procedures. The inability to make a decision could be caused by a mental health problem, dementia, learning disability, or physical problem such as toxic confusion, a stroke, brain injury or the effects of drugs or alcohol.
- 1.3** People who work in health and social care will be affected by the MCA and will need to know about it. Those who commission care will have a responsibility to be aware of provider responsibilities under the MCA to ensure compliance through contracting processes with the legislation.
- 1.4** The MCA is accompanied by a statutory Code of Practice² which explains how the MCA will work on a day-to-day basis and provides guidance to all those working with, or caring for, people who lack capacity. Those who work with people who lack capacity in a professional or paid role have a legal duty to have regard to the Code of Practice.
- 1.5** The MCA is not about detention or compulsory treatment under the Mental Health Act 1983. The 1983 Mental Health Act is primarily about people who are diagnosed as having a mental health problem, which requires that they be detained or treated in the interest of their own health or safety or with a view to protecting other people.
- 1.6** The assessment of mental capacity and decision making on behalf of those who lack capacity is a complex process. Those who are involved in assessments of capacity and acting of behalf of others have a duty to ensure

¹ For the purpose of the policy reference will be made to Adults this includes young people aged 16-17 unless specified.

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

their practice is evidence based and in keeping with available guidance. Knowledge of this policy and procedure alone will not be sufficient to ensure practice is defensible, and staff will have to be familiar with the contents of the MCA and its associated Code of Practice and related guidance if their role requires it.

- 1.7** MCA, as an Act of Parliament, will be subject to ongoing clarification by the courts. This policy and procedure will be subject to periodic amendment in the light of case law or changes to the legislation.

2 Aim

- 2.1** This policy will ensure that NHS Wakefield CCG commissions services that are mindful of, and fully utilise the Mental Capacity Act. It will also ensure that CCG staff meet the requirements of the Act

3 What is the Mental Capacity Act

- 3.1** The MCA applies in England and Wales to everyone who provides care, treatment or support for people over 16 years of age who may lack capacity to make decisions for themselves.

3.2 Fundamental principles of MCA

- There must always be the presumption that someone has capacity to make decisions for them self. A lack of capacity, and therefore the need to act in a person's best interests, must be clearly determined;
- There is a statutory definition of a person who lacks capacity and sets out a test for determining whether or not a person is capable of making a particular decision, this includes a checklist for determining what is in the best interests of a person who lacks the capacity to make decision for themselves;
- The Act provides clear information to help individuals plan ahead for the possibility that they may lose capacity to make decisions in the future;
- It provides clarification regarding the decisions and actions people can take on behalf of a person who lacks capacity;
- The Act provides a level of protection from liability for the acts taken on behalf of an incapacitated person if it can be shown that the provisions of the Act have been followed;
- It places on those working with a person who lacks capacity, a statutory duty to consult other relevant people involved with the person, not just "next of kin" or family members;
- There is provision for a statutory advocacy service for people who lack capacity - the Independent Mental Capacity Advocate (IMCA) who in some circumstances must be consulted and in other circumstances may be consulted;
- It defines a criminal offence of wilful neglect or ill treatment of a person who lacks capacity;
- It provided safeguards concerning research involving people who lack capacity;

- It defines the role of the Court of Protection (CoP) and the Office of the Public Guardian (OPG).

4 Scope of the Policy

- 4.1** This document aims to clarify issues related to the implementation of the MCA by NHS Wakefield CCG.
- 4.2** This document does not seek to reproduce the MCA, nor its associated Code of Practice or guidance. Those who are involved in assessing needs or providing care, support or treatment to a person who lacks capacity are legally obliged to implement the MCA and to have regard to the Code of Practice.

5 Accountability

The Duties and responsibilities of staff within NHS Wakefield CCG are described below:

- 5.1** NHS Wakefield CCG Chief Officer has overall accountability.
- 5.2** The Chief of Service Delivery and Quality is responsible for ensuring that services are commissioned with regard to the MCA and for ensuring that staff pay due regard to the Mental Capacity Act 2005.
- 5.3** The MCA lead for NHS Wakefield CCG will represent the organisation at local / regional networks, and contribute to delivery of the local project plan as appropriate.
- 5.4** All managers have a responsibility for ensuring staff have an understanding of the Mental Capacity Act 2005.
- 5.5** All staff have a statutory duty to ensure that they adhere to the principles of the Mental Capacity Act 2005.
- 5.6** The Integrated Governance Committee is the group that is responsible for the formal approval of this document.

6 Equality Impact Assessment

- 6.1** NHS Wakefield CCG aims to design and implement services, policies and measures that meet the diverse needs of its service, population and workforce, ensuring none are placed at a disadvantage. NHS Wakefield CCG uses a single equality impact assessment for all its policies and procedures. The Equality Impact Assessment for this policy is included as Appendix 1.

7 Implementation and Dissemination

- 7.1** This policy, following ratification by the Integrated Governance Committee, will be accessible via 'Skyline, the CCG intranet.

8 Guiding Principles

This policy reflects the key principles of the MCA. Following these principles ensures protection for both the incapacitated person and those acting on their behalf.

- **Principle One**
Presumption of capacity – every adult has the right to make his or her own decisions and must be presumed to have capacity to do so. A lack of capacity, and therefore the need to act on the person's behalf, must be clearly decided upon and documented.
- **Principle Two**
Individuals have the right to be supported to make their own decision. They must be given all the appropriate help they require before it is decided that they are unable to make their own decisions.
- **Principle Three**
Individuals have the right to make what may seem to be unwise decisions. This does not mean that they lack capacity. Although risk factors and the individual's understanding of these will be an aspect of any assessment of capacity.
- **Principle Four**
Anything done for, or on behalf of, a person who lacks capacity must be in their best interests.
- **Principle Five**
Anything done for, or on behalf of, a person who lacks capacity must be the least restrictive option and take into account their rights and freedom of action.

9 Helping people make decisions (Chapter 3 of the Code of Practice)

- 9.1** People should be helped to make their own decisions, even when circumstances mean that this is more difficult for, for example: when a person is suffering from a mental health problem, or has a learning disability which may compromise their ability to make some decisions. When working with a person who needs to make a decision, staff must start from the presumption that the person has capacity.
- 9.2** Providing appropriate help with decision-making should form part of care planning processes for people receiving health or social care services. Examples include:
- Principles of Assessment and Care Management;
 - Person Centred Planning for people with learning disabilities;
 - The Care Programme Approach for working age adults receiving secondary mental health services;

9.3 Consideration needs to be given to appropriate means of support to help the person make a decision. The following list is not exhaustive and appropriate support will be developed to meet individual needs:

- Relevant information should be provided in a language the person will understand, preferably in the person's first language;
- Use of signing, translation services, or Makaton should be considered, if the person communicates using non-verbal means, and help should be sought to understand this;
- Alternatives or the range of options available should be explored and explained;
- Risks, benefits and potential consequences of making the decision and not making the decision should be explained;
- 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)?
- Relatives, friends or carers 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?

10 What happens in emergency situations? (Chapters 3, 5, 6, 9 and 10 of the Code of Practice)

Clearly, in emergency medical situations (for example, where a person collapses, or for some unknown reason is unconscious requires urgent medical care), immediate actions may need to be taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies.

However, even in emergency situations, healthcare staff should try to communicate with the person and keep them informed of what is happening. Advance decisions to refuse treatment may be applicable in these circumstances, but there should not be a delay with emergency treatment whilst trying to locate this if there is no evidence that such a directive exists.

11 Assessing capacity. (Chapter 4 of the Mental Capacity Act Code of Practice)

The presumption that all adults have capacity is central to the MCA. Where a person has the capacity to make a particular decision, then they should ensure others know what their decision is. If a person has capacity, they are allowed to make a decision which appears unwise, or unsafe, this still needs to be respected. Those making a decision, in that person's best interest, on behalf of another person, must first determine that the person on whose behalf they are acting lacks the capacity to make the particular decision.

- 11.1** Where there are grounds to doubt a person's capacity to make a particular decision, an assessment of capacity must be done in accordance with the MCA and its related Code of Practice (particularly Chapter 4). Any deviance from the guidance contained in the Code of Practice must be logical, rational, reasonable and defensible, and clearly documented.
- 11.2** It is important to recognise that people who lack capacity can still be very articulate and provide a rationale in their reasons for making or not making a particular decision. This needs to be considered when assessing whether or not the person has the capacity to make the decision in question. An example of this may be a person with a personality disorder, where they may articulate very well their reasoning behind a particular decision but their disorder may prevent them from appreciating the consequences of their decision.
- 11.3** A person may lack capacity for a number of reasons: capacity is not dependent on any condition alone, but the effects a condition may have on the ability to make decisions. 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 (prescribed or illegal) or alcohol;
 - Mental health problems including: psychoses, anxiety, phobias, depressive illness, other mood problems, Personality disorders and Diogenes syndrome.
- 11.4** It is important to remember that capacity is decision and time specific. This is important: people are not assumed to be incapable of making decisions because of a diagnosis. A person should be considered to have capacity for each and every decision, and a person may have the capacity to make one decision, but not another, more complex decision, for example: the decision to decide how to spend their money every week, but not how to invest their savings. If a person has been assessed as not having capacity to make a particular decision one can then make a decision on their behalf and act in their best interest.
- 11.5** Loss of capacity may be temporary or could be permanent due to life-long condition (such as a Learning Disability).

12 Recording assessments of capacity.

- 12.1** A recording form for the purposes of documenting the assessment of capacity is available for use and is available at Appendix 4. The form need not always be used as in most cases assessment of capacity will take place on a regular,

more informal level. The following situations represent serious decisions that may need to be made on a person's behalf, and as such could result in formal or legal challenge. It is therefore recommended that clear documented evidence of the assessment of capacity, using the form provided, is retained:

- The decision is about serious medical treatment;
- The decision concerns longer 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 such a form would be useful;
- There are concerns about conflicting opinions (e.g. between professionals, carers, the person being assessed);
- If requested by the Police for the purposes of furthering their enquiries (for example, MCA section 44 charges).

12.2 Most regular decisions about capacity will be related to the care and support of people. Where lack of capacity is in the medium to longer term, it may be useful to make this the subject of care planning (see paragraph 20 of this document). It is important to note that because an assessment of capacity and the judgement of what is in the person's 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 their best interests in respect of issues which have not yet arisen. Care plans need to indicate what issues should be considered in assessing capacity and what should be considered when judging best interests. An example of such a care plan is given at Appendix 5. Where a care plan is used, entries in the notes relating to the implementation of the care plan will demonstrate the implementation of the MCA.

13 Mental Capacity and Risk

13.1 It is a fundamental principle that people live with elements of risk in their personal life. Where a person is assessed as lacking capacity to make a decision, consideration of what action is in their best interests will need to take into account a balance of risks and needs/benefits. It is important that when assessing capacity, a person is able to understand the risks associated with either making, or not making a decision, and this understanding is considered as part of assessment. Does the person understand the risks involved? Understanding and accepting risks is an important part of decision making. If the person is unable to understand the risks it is likely that they lack capacity to make that decision. For example a person with fluctuating capacity, who is unable to understand or accept that their capacity fluctuates and the risks associated with this.

13.2 When considering capacity to make a decision, assessors must decide if the person fully understands the consequences of their risk taking behaviour - for example: a person who is unable to swallow properly, refusing a liquidised diet because they find it unacceptable, must be able to appreciate the

consequences of eating a normal diet, and therefore to understand that it could lead to injury, distress and even death.

- 13.3** Where a person's risk taking behaviour may lead to risk to other people, public protection must be considered. Where a person with capacity decides to undertake risk taking behaviour which places others at risk, steps must be taken to address this, including involvement of the police and/or child protection agencies if necessary. It is therefore inevitable, that those who have capacity to make decisions may live with an element of risk in their lives.
- 13.4** It is equally inevitable that those who lack capacity to make decisions are sometimes exposed to an element of risk and it is essential that risk management plans are put into place in order that they are protected as far as practicable. This may mean that actions are taken, against the person's apparent (although incapacitated) wishes.
- 13.5** 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 about the issue in question or family members and/or other professionals disagree with the decisions taken by professionals. These risks must be taken seriously and staff and their managers should address such risks. Strategies must be in place to ensure staff safety.

14 Safeguarding adults

- 14.1** This part of the policy should be read in conjunction with the Safeguarding adults - Multi-agency policy and procedures for West Yorkshire and North Yorkshire 2015³
- 14.2** People who lack capacity are amongst the most at risk of abuse and/or neglect. It is important to recognise that where a person's ability to make some decisions for themselves is impaired, the decisions they are able to make, become more important. Most decisions are encompassed by the MCA, ranging from decisions about accommodation and medical treatment, to what to wear, what to eat and what to watch on television.
- 14.3** Mental capacity may 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 their future care and support, even if this means that they wish to remain within an abusive environment. If however a person in an abusive situation lacks capacity, then professionals will need to make a decision on their behalf based on that person's best interests. This may mean a complex set of circumstances will need to be considered, including the effects of the person remaining within the abusive environment and the effects of removing

³<http://www.wakefield.gov.uk/Documents/health-care-advice/adult-services/safeguarding/safeguarding-adults-from-abuse/safeguarding-adults-board-policy-procedure.pdf>

them from the environment. The wider social aspects of a person's circumstances must be considered when determining what is in his or her best interests.

- 14.4** A person who wilfully neglects or ill-treats a person who lacks capacity can be prosecuted under section 44 of the MCA which carries a custodial sentence. Since the introduction of the Act there have been a number of successful prosecutions.

15 Planning ahead for the future (Chapter 7 of the Code of Practice)

- 15.1** People can plan ahead for a time when they may lack capacity. The MCA introduces three ways of doing this:

- Advance decisions to refuse treatment;
- Statement of wishes, feelings and beliefs.
- Lasting Powers of Attorney;(see section24)

- 15.2 Advance decisions to refuse treatment** (previously commonly known as living wills) existed prior to the MCA. People can make an advance decision to refuse specified treatment in the future which may include refusal of life sustaining treatment. Advance decisions 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.

- 15.3** Advance decisions may set out the circumstances in which the refusal will apply. Advance decision to refuse treatment (not life sustaining treatment) need not be in writing.

- 15.4 Advance decision to refuse life sustaining treatment** must be in writing. It must be signed by the person making the advance decision (known as P) or by some other person in P's presence and by his direction in the presence of a witness who must also sign it or acknowledge his signature. It can be in any format and might be in the person's medical notes. 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. If a person has already made an advance decision to refuse treatment, they should be advised and encouraged to review it in light of the requirements of the MCA.

- 15.5** If 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 particular 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 their future;

- If it is about life sustaining treatment, is it signed, witnessed and contains a statement recognising that it applies to life sustaining treatment?

15.6 In considering the applicability of the advance decision, staff 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 ground for believing that there have been changes in circumstances which would have affected the person's advance decision (e.g. advances in medical treatment).

15.7 A person cannot make an advance decision to refuse basic or essential care, such as warmth, cleanliness, offer of oral food and fluid however it can be used to refuse artificial hydration and nutrition. An advance decision cannot be made to require the provision of a particular medical treatment, they can only refuse treatment. If a person has made a statement, indicating that they have preferred treatments, these should be given due consideration when determining best interests. People cannot make advance decisions to ask for their life to be ended.

15.8 **Statements of wishes, feelings and beliefs** are a more informal mechanism which can be used by a person to let family, friends, and professionals who will be involved in their care of their wishes should they lose capacity to make their own decisions in this respect at some point in the future. This could include anything that is important to the person such a vegetarian diet, religious practices, the wish to have a much loved pet looked after, or moved with the person into residential care.

15.9 Those making a best interest decision 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. Statements of wishes, feelings and beliefs need not be in writing, but those that are written down and given to family, friends, health and social care professionals are more likely to be followed.

15.10 Where staff are involved with a person who wishes to plan for the future, they should give advice, support and assistance where this is appropriate.

16 Best Interests (Chapter 5 of the Code of Practice)

16.1 It is important to remember that when a person lacks capacity to make a particular decision, it follows that they do not have the capacity to either consent or object to the proposal. 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 they may still lack the ability to make an informed decision and therefore lack capacity.

16.2 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?
- Is there a Deputy appointed by the Court of Protection?
- Is there an advocate already involved?
- Is there a duty or power to consult an Independent Mental Capacity Advocate;
- 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?

16.3 A form to help formulate and record best interest decisions is available at Appendix 6. There is no legal requirement that this form is used but staff will find it useful in working systematically through the best practice checklist and record their rationale for future reference. It is recommended that either this form is used, or a clear account is made in the patient record, either in the form of assessments, care plans or ongoing records, to show how a determination of how best interests was established. In cases with higher levels of complexity, it would be appropriate to use a "balance sheet" approach to help with decision-making as is used in the Court of Protection. Examples are in the Case Study section (Section 4) of the British Psychological Society Best Interest Guidance ⁴

17 Duty to consult as far as is practicable and appropriate (Chapter 5 of the Code of Practice)

17.1 The MCA extends the duty to consult other people in relation to considering best interests.

17.2 Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care? If practicable and appropriate you must consult with, and take in to account, the views of the following:

⁴ http://www.bps.org.uk/system/files/Public%20files/Policy/rep_67_best_interests_web.pdf

- Anyone the person has previously nominated to be consulted (The Nominated Person);
- Lasting Power of Attorney appointed (acquire proof from the OPG that this has been registered);⁵
- Enduring Power of Attorney appointed(acquire proof from the OPG that this has been registered);
- A Deputy appointed by the Court of Protection(acquire proof from the OPG that this has been registered);
- 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 significant involvement with the person.

17.3 The assessor must consider whether they should consult further, depending on the nature of the decision and the seriousness of the consequences. The consultative body for decisions, where appropriate, may include specialist advisors, such as speech and language therapists, mental health professionals, a specialist in learning disabilities, psychologists etc.

17.4 Reasons where consultation may not be practicable or appropriate may include the following:

- The person lives abroad and has no contact with the person;
- A relative who is estranged;
- A family member who refuses to be consulted;
- A family member who themselves lack capacity to be involved in the decision making process;
- A family member may not be perceived to be acting in the best interests of the person without capacity.

18 Decisions to which the Mental Capacity Act does not apply. (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 marriage or a civil partnership;
- consenting to have sexual relations;
- consenting to a decree of divorce on the basis of two years' separation;
- consenting to the dissolution of a civil partnership on the basis of two years separation;
- consenting to a child being placed for adoption or the making of an adoption order;
- discharging parental responsibilities for a child in matters not relating to the child's property;
- giving consent under the Human Fertilisation and Embryology Act 1990;

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/286541/OPG100_Apply_to_search_PG_register_s.pdf

- a person cannot vote on behalf of a person who lacks capacity;
- special provisions apply to people who are subject the Mental Health Act.

19 Record Keeping.

19.1 All those involved in the care and treatment of a person who lacks capacity must keep a record of long term or significant decisions made about capacity. The record should be made in the place where details about a patient are regularly made such as the case file or care plan records. The record should show:

- How the issue of capacity was determined;
- What the decision was and who was the decision maker;
- How the decision was made;
- Why the decision was made – best interests checklist;
- Who was involved;
- What information was used

19.2 Recording decisions in this way will help staff to demonstrate why they had a reasonable belief that the person lacked the capacity to make the decision in question. Where a person is judged to lack capacity to consent to day-to-day decisions such as what to watch on TV, what to wear etc, elaborate record keeping is not required. However if a member of staff's decision is challenged, they must be able to describe why they had a reasonable belief of lack of capacity. The decision about lack of capacity should always be recorded in the person's case file. Although this does not need to be done on a daily basis the record should note the decisions and note this it will be reviewed regularly unless or until capacity is regained.

19.3 It is important to note that where a person lacks capacity to make a particular decision, e.g. consent to treatment, or sharing information, then they cannot sign a consent form or any other document relating to consent or refusal. In these cases, those acting on their behalf must act in the person's best interests and records should reflect this.

20 Care planning

20.1 It is important to note that because an assessment of capacity and a judgement of best interests are 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 their best interests in relation to issues which have not yet arisen. Care plans need to indicate what issues should be considered in assessing capacity and what should be considered when judging best interests. An example of such a care plan is given at appendix 5. Where a care plan is used, entries in the notes relating to the implementation of the care plan will demonstrate the implementation of the MCA.

20.2 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.

- 20.3** Consideration should be given to writing Advance Care Plans when the person has the mental capacity to participate in the process.
- 20.4** Advance Care Planning is described as a process of discussion between an individual and their care providers irrespective of discipline. If the individual wishes, their family and friends may be included. An Advance Care Plan might include:
- The individual's concerns;
 - Their important values or personal goals for care;
 - Their understanding about their illness and prognosis;
 - Their preferences for types of care and treatment that may be beneficial in the future and the availability of these.

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

21 Confidentiality and Data Protection (Chapter 16 of the code of Practice)

- 21.1** This part of the policy should be read in conjunction with the NHS Wakefield CCG Confidentiality and data protection policy.
- 21.2** Individuals have a right to confidentiality. Information can be shared about an individual where the person has capacity and agrees to share information, where there is a legal duty to do so, or where legislation permits the information sharing and there are grounds to justify the information sharing such as there being an overriding public interest.
- 21.3** Where a person lacks capacity to make a decision regarding sharing of information, the following guidance applies (alongside the guidance contained in the Confidentiality and data protection policy)
- Information can be shared in the best interest of the person who lacks capacity. 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 they had the capacity to do so) for a person or persons to access their 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 their wishes and feeling be known about sharing information, and these must be considered when considering sharing information for a person who lacks capacity.
- 21.4** If there is any doubt about sharing information, advice should be sought from the CCG Caldicott guardian or Senior Information Risk Owner (SIRO)

22 Restraint including restriction or Deprivation of Liberty (Chapter 6 of the Code of Practice)

22.1 Section 6 of the MCA defines restraint as the use or threat of force to secure the doing of an act which the incapacitated person resists, or which restricts the liberty of movement of the person 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 restraint 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 MCA.

22.2 The MCA (section 6(5)) makes it clear that the act does not provide protection for an act which deprives a person of his or her liberty within the meaning of the Human Rights Act. Under the Safeguarding Adults Multi-agency policy and procedures this is regarded as abuse and must be reported under that policy.

22.3 On the 19th March 2014 the Supreme Court handed down the judgement in the case of “P v Cheshire West” a “P and Q v Surrey County Council”⁶ in relation to deprivation of liberty, seeking authorisation and ensuring safeguards are in place when a person is deprived of their liberty. The Supreme Court established the ‘acid test’ for when a person is deprived of their liberty for the purpose of Article 5 of the European Convention on Human Rights. The acid test is that:

The person is

- Under continuous supervision and control
- They are not free to leave
- They lack the capacity to consent to the arrangements

For further guidance please refer to the Deprivation of Liberty Safeguards (DoLS) code of practice⁷, see page 25 of the SA Multi-agency policy and procedures for West Yorkshire and North Yorkshire or contact your safeguarding lead or the LA MCA team on 01924 304340.

⁶ https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

⁷

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

23 Independent Mental Capacity Advocate (IMCA) (Chapter 10 of the Mental Capacity Act)

- 23.1** Wakefield MDC and Kirklees MDC have jointly commissioned an Independent Mental Capacity Advocacy (IMCA) service. The organisation “Together for Mental Wellbeing” provides the service throughout the two districts.
- 23.2** Referral to the IMCA is restricted to a set of defined circumstances, as it is designed to assist the most vulnerable members of society who not only do not have the mental capacity to make a decision, and who have no family or friends that it would be appropriate to consult. IMCA’s must be an independent person and cannot be involved in providing care or treatment for the person in a professional capacity or for remuneration, or have links to the person instructing them, to the decision maker or other individuals involved in the individual’s care.
- 23.3** Staff have a legal duty to instruct the IMCA if the person is “un-befriended’ if a decision is required regarding 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).
- 23.4** The IMCA may be instructed in cases where a care review is to consider reviewing accommodation arrangements, provided the person concerned lacks capacity to make the decision and is ‘un-befriended’.
- 23.5** The IMCA may also be instructed where the person who lacks capacity is the subject of adult protection procedures, either as a victim or perpetrator, whether or not the person is un-befriended. This would be considered where it is thought to be of some benefit to the person.
- 23.6** Guidance on how to instruct an IMCA and how to refer to the service are included at Appendix 7. The website for the IMCA in Wakefield is:
<http://www.together-uk.org/projects/kirklees-and-wakefield-imca/>

24 Lasting Power of Attorney (Chapter 7 of the Code of Practice)

- 24.1** Lasting Power of Attorney (LPA) replaced the system of Enduring Power of Attorney (EPA). This meant that from October 2007, only new LPAs could be created. If however, people had already made EPAs and they have not been registered, these could still be registered after October 2007. The effect of this is that for many years both systems will be in place.
- 24.2** There are two types of LPA:
- Property and financial affairs;
 - Health and Welfare.
- 24.3** The property and financial affairs LPA is similar to an EPA. It only relates to financial matters and can be used when the person still has capacity.

- 24.4** The health and welfare LPA can only be used when the person who created it lacks capacity.
- 24.5** LPAs can only be made when the person making it 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 as an Attorney.
- 24.6** The health and welfare LPA means that a person can nominate another person to make decisions on their behalf in relation to both health and personal welfare matters.
- 24.7** It is important to read the LPA to understand the extent of the Attorney's power. If there is any doubt advice should be sought from the OPG.
- 24.8** For either a property and financial affairs or a health and welfare LPA to be valid it must be registered with the Office of the Public Guardian. Without registration the powers within the LPA cannot be used. An Attorney will be able to produce the original (embossed) documentation from the Office of the Public Guardian. If there are doubts as to the existence of a valid LPA, the Office of the Public Guardian can be contacted to check these details. The contact details and the type of assistance the Office will provide can be found at Appendix 10.
- 24.9** If the person who lacks capacity has created a health and welfare LPA, the Attorney will be the decision maker on all matters relating to the person's care and treatment covered by the LPA. The LPA may specify limits to the Attorney's authority, if the matter which requires a decision is not covered by the LPA then the attorney does not have any powers under the LPA to make the decision. A health and welfare LPA can authorise the Attorney to give or refuse consent to treatment on the person's behalf. 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.
- 24.10** If the decision is about life sustaining treatment, the Attorney will only have the authority to make the decision if the LPA specifies this.
- 24.11** EPAs only relate to property and affairs and do not give the person with the EPA the right to make health or welfare decisions on behalf of a person without capacity.
- 24.12** An EPA can be used when the person who has made the EPA still has capacity, and the person wishes for it to be used whilst he still has capacity.
- 24.13** If staff have concerns that those who are exercising powers under either an EPA or an LPA in respect of an incapacitated person, are not exercising them in the best interests of the incapacitated person they may register their concerns with either the Office of the Public Guardian or the Court of Protection.

24.14 NHS employed Staff must not agree to be an Attorney for an individual for whom they are providing care, treatment or support.

25 The Court of Protection (Chapter 8 of the Code of Practice)

25.1 The Court of Protection has jurisdiction relating to the whole of the MCA 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.

25.2 The issues that may be referred to the Court are those serious complex matters which, after considering all options available, remain irresolvable. The Court should be seen as a provision of last resort. The Court can make a decision where there is a single issue or appoint a Deputy where there are a series of ongoing decisions to be made.

25.3 Court Appointed Deputies. Where the Court believes that there an ongoing decision-making powers on behalf of a person lacking capacity, it may make an appointment under Section 16 (2) of the Mental Capacity Act to appoint a Deputy to act for and make such decisions on behalf of the person. In appointing a Deputy, the Court is required to have regard to the principle that the powers conferred upon a Deputy are to be as limited in scope and duration as is reasonably practicable in the circumstances.

26 The Office of the Public Guardian (Chapter 14 of the Code of Practice)

26.1 The Office of Public Guardian (OPG) is the registering authority for 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. The Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges his or her duties.

27 Wilful Neglect or Ill Treatment of a Person who lacks Capacity (Chapter 14 of the Code of Practice)

27.1 Section 44 of the MCA defines the criminal offence of wilful neglect or ill treatment of a person who lacks capacity. This is punishable by a fine or a sentence of up to five years imprisonment or both.

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

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

- have deliberately ill treated the person; or
- be reckless in they way they were treating the person.

- 27.4** It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.
- 27.5** 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 they knew they had a duty to do.
- 27.6** Where ill treatment or wilful neglect is suspected, the police must be informed and the Safeguarding Adults Procedure should be instigated.

28 Protection from Liability (Chapter 6 of the Code of Practice)

- 28.1** Section 5 of the MCA offers protection to those making decisions or taking actions on behalf of incapacitated people from civil and criminal liability in respect of those decisions/actions as long as the decisions/actions are carried out in accordance with the provisions of MCA. 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 they lack capacity.
- 28.2** To ensure protection of 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 carry out best interest decisions.
- 28.3** 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.
- 28.4** NHS Wakefield CCG expects that staff who work with people who may lack capacity are familiar with the contents of the MCA and its associated Code of Practice, and 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 Disputes and Disagreements (Chapter 15 of the Code of Practice)

- 29.1** The Code of Practice makes it clear that any disputes relating to either assessment of capacity or best interest needs to be resolved quickly and in a cost effective manner.
- 29.2** 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 family members disagree with each other. It is also possible that there will be several options to act in a person's best interests and it may be difficult to get a consensus opinion on the best action to take.

29.3 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.

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

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

29.6 Recourse to the Court of Protection should be the last resort if no agreement can be reached.

30 Research (Chapter 11 of the Mental Capacity Act)

30.1 The MCA sets out parameters for when research carried out on, or in relation to a person who lacks capacity to consent will be considered lawful.

30.2 An "appropriate body", which would normally be a research ethics committee, will need to agree the research is safe, related to the person's condition and likely to produce a benefit to the person that outweighs risk/burden.

30.3 Carers or nominated third parties must be consulted and agree that the research takes place. If the person shows any signs of resistance or indicates in any way they do not want to take part, they must be withdrawn from the research.

30.4 Further information on research involving people who lack capacity is included at Appendix 8.

31 Interface with the Mental Health Act (Chapter 13 of the Code of Practice)

31.1 The MCA can be used to treat a person for mental disorder when they cannot consent because they lack capacity and where the treatment is in their best interests.

31.2 The MCA cannot be used to detain a person in hospital. Where a person needs to be detained because they are suffering from a mental disorder, then they should be assessed with a view to detention under the Mental Health Act.

31.3 If a person is detained under the Mental Health Act, the MCA does not apply to treatment given for mental disorder, which can be given without consent under the Mental Health Act.

- 31.4** 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.
- 31.5** Where a person has made an advance refusal of medical treatment for mental disorder, the advance decision can be overruled if the treatment is given under the Mental Health Act.
- 31.6** For most other purposes, the MCA will still apply to those detained under the Mental Health Act, for example for the treatment of physical disorders.

32 Children and Young people aged 16 – 18 (Chapter 12 of the Code of Practice)

- 32.1** There is an overlap between the MCA and the Children Act 1989 for young people aged 16 and 17 years, but most of the provisions of the MCA apply. Decisions made on behalf of young people aged 16 and 17 when they lack capacity must be in their best interests, and the decision maker must consult those with parental responsibility. A birth mother always has parental responsibility (unless the child has been adopted from her care), a father will have parental responsibility if he was married to the child's mother at the time of the birth, or he is named on the child's birth certificate - children born after December 2004. For children subject to Care Orders, the Local Authority will share parental responsibility with those detailed above.
- 32.2** Parts of the MCA do not apply to young people aged 16 and 17. They cannot make a Lasting Power of Attorney or an advance decision to refuse treatment. If a child (or their parent) refuses to agree to medical treatment, the Family Court may be asked to make an order indicating the care the child should receive. The Court of Protection only has power to make a will on behalf of a person over the age of 18.
- 32.3** For those aged under 16 only two parts of the MCA apply:
- The Court of Protection can make a decision relating to property and affairs of a person under 16 who is likely to still lack capacity to make financial decisions when they reach the age of 18;
 - Offences of wilful neglect or ill treatment of a person who lacks capacity can also apply to those younger than 16.

See Appendix 9 for further information or consult the Code of Practice.

33 References and Associated Documentation

Mental Capacity Act

2005: http://www.opsi.gov.uk/acts/acts2005/ukpga_2005009_en_1

Mental Capacity Act 2005 Code of Practice:

<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/SocialCare/Deiveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm>

Richard Jones, Sweet & Maxwell (2009) Mental Capacity Act Manual (4th Edition)

Mental Capacity Act Implementation Programme (2nd Edition) (2007) Making Decisions: A guide for people who work in health and social care.

Care Services Improvement Partnership (2006) Mental Capacity Act 2005 self Assessment Tool.

DoH Advance Care Planning: A Guide for Health and Social Care Staff (2007) University of Nottingham

DH (2007) Independence, Choice and Risk: a guide to best practice in supported decision making

WDC Family Services and NHS WD (2009) Deprivation of liberty Safeguards Policy Guidance

Making Decisions - A Guide for People who work in Health and Social Care: <http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/SocialCare/Deiveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm>

Safeguarding Adults and Safeguarding Children Policies

The Data Protection Act (1998)

Disability Discrimination Act (1995)

Human Rights Act (1998)

The Mental Health Act (1983)

The Care Standards Act (2000)

National Health Service and Community Care Act (1990)

Human Tissues Act (2004)

34 Appendices

Appendix 1 – Equality Impact Assessment

Appendix 2 – The process of decision making

Appendix 3 – Decision making flow chart

Appendix 4 – Record of assessment of capacity

Appendix 5 - Examples of care planning

Appendix 6 – Record of best interest decisions

Appendix 7 - Independent Mental Capacity Advocacy Service referral information

Appendix 8 – Research Safeguards

Appendix 9 – The Mental Capacity Act and Children and Young People

Appendix 10 – The Office of the Public Guardian

Appendix 1. Equality Impact Assessment.

1. Name of policy, strategy, project or service:	NHS Wakefield CCG: Mental Capacity Act Policy Guidelines	
2. What are the main aims and objectives of the policy / strategy or project?	<p>Aims:</p> <ul style="list-style-type: none"> - to provide key information about the Mental Capacity Act (MCA) 2005, including the additions from 2007. <p>Objectives:</p> <ul style="list-style-type: none"> - To outline the principles of the act, taking into account: <ul style="list-style-type: none"> •the right of the individual to make their own decisions •the necessity to support individuals to make their own decisions •the importance of working in the patient’s best interests •how decisions made on behalf of the patient must be the least restrictive option for them <p>Within the policy itself:</p> <ul style="list-style-type: none"> - To assess capacity - To define role of the attorney - To explain role of court appointed deputies, Court of Protection, Public Guardian - To protect vulnerable people - To outline research parameters <p>Outcomes:</p> <p>Patient choice for the individual with their mental state taken into consideration, always acting in their best interests, hence adherence to the MCA 2005 and its subsequent additions.</p>	
3. Could any groups be negatively affected by this policy/ strategy?	Yes	No ✓
	<p>Please explain:</p> <p>Equality Impact Assessments have been conducted by the Ministry of Justice on the full document; these can be viewed at http://www.justice.gov.uk/docs/mc-equality-impact.pdf</p> <p>Race</p> <p>Documentation used in relation to the MCA in Wakefield specifically asks for the first language of the patient, taking those who do not have English as a first language into consideration. A subsequent question asks how</p>	

these been dealt with, ensuring that staff have thought about using an interpreter, or of having materials translated for the Attorney of the patient if necessary.

The full Mental Capacity Act makes reference to the possibility of a patient losing some of their verbal skills due to a deterioration in their mental health and hence preferring to speak in their first language (assuming it is not English), even if they speak good English. All issues associated with people from Black or Minority Ethnic (BME) groups are considered within the policy. The national EIA carried out on the full Mental Capacity Act reports that Stakeholders representing black and minority ethnic (BME) communities submitted evidence to the Joint Committee considering the Mental Incapacity Bill in 2003, which was then combined with public consultation and fed into the updated document. Stakeholder events were held to ensure that the opinions of people identifying with BME communities were sought. In May 2006, 70 BME organisations were invited to an event, of which 23 attended. This event explored how the Act might impact on BME communities, which is important considering that rates of admission into psychiatric hospitals are three or more times higher for black and white-black mixed groups compared with the average. Another national statistic states that black groups are up to 44% more likely to be detained under the Mental Health Act compared to the average; therefore it was very important that those from BME groups had the opportunity to comment and help formulate the policy.

Disability

Disability is an important issue here as the mental capacity of a person may be altered by an existing disability, which they may have been born with, or developed in later life, or a disability may develop due to a change in a person's mental health; for example, when someone becomes brain damaged by e.g. a road accident. The Disability Discrimination Act (DDA) defines a disabled person as 'someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'; this includes mental health conditions such as dementia, depression, bipolar disorder, obsessive compulsive disorder,

schizophrenia and self-harming. The MCA outlines the need for transparency; it must never be assumed that a person is lacking in capacity just because they have e.g. a learning disability. The full MCA has numerous case studies relating to disability, several of which give a specific example of a situation where alterations could be made to e.g. assist a patient with a decision-making process. The MCA suggests that organisations take measures to enable those with profound learning difficulties to express themselves; this might mean using pictures and very simple terminology. Patients may be helped by having any documentation read to them in straightforward language.

Gender

The MCA is gender neutral. The full MCA uses examples of potential scenarios relating to mental health and capacity, and there is a balance of case studies involving men and women.

Age

The MCA generally only affects those who are 16+. The Policy will not have a particular impact on any age-groups due to its all-encompassing nature. The examples it cites throughout the full Act refer to a variety of people of different ages, including older people with dementia, people across the age spectrum with learning difficulties as well as those of all ages who have been affected by neurological injury.

Sexual Orientation

The MCA takes the best interests of the patient into consideration, including their sexual orientation. For example, if a patient was in a same-sex relationship, the person able to act in their best interests might be their partner, even if they were not in a legally binding civil partnership. As long as this is factored in to any decision made as to who is the most appropriate person to make decisions if an individual is not considered mentally capable, there will not be a negative impact on people identifying as lesbian, gay, bisexual or transgender. Sensitivity is obviously required where individuals or the patient is not open about their sexuality, and this must be respected by all concerned.

Religion / Belief

One of the three key provisions of the MCA to protect those who are vulnerable is the appointment of an Independent Mental Capacity

Advocate (IMCA) who may be appointed if the patient has no one to make decisions for them. The summary of the MCA refers to the 'person's wishes, feelings, beliefs and values', all of which must be taken into consideration where issues of mental capacity arise. This incorporates any religious needs which the individual may have; these should be met as far as possible, even when the mental capacity of the individual is questionable. Every effort must be made to find out about the religious stance and hence needs of the individual, and the policy outlines this. In NHS Wakefield CCG Mental Capacity Act policy and guidance practitioners are reminded that the question is asked – 'are you aware of any statements of wishes, feelings, beliefs and values outlined by the person?' This enables the person when completing the assessment to make a note of anything which the patient has made clear prior to the deterioration of their mental state; this will usually be where an advanced decision has been made to e.g. refuse treatment on the grounds of it being the person's choice based on their religious beliefs. The 'best interests check list' specifically asks if there are any beliefs and values (religious, cultural or moral) which would be likely to influence decisions relating to a person's mental capacity, and there is space for a full explanation of this to be given on the form. The full MCA outlines the content of this checklist – encouraging participation, identifying relevant circumstances, finding out the person's views, avoiding discrimination on any grounds (including their age, appearance, condition, behaviour, religious affiliations and beliefs, sexual orientation etc, all of which should be covered by the mandatory Equality and Diversity training received by all staff in NHS Wakefield CCG) and assessing if the patient might regain capacity. The checklist also covers the consultation of others which may reveal important information about the way in which the individual would want to be treated in accordance with their religious beliefs.

4. Could there be a negative impact under current legislation?	Yes	No ✓
	Please explain: Policy reflects national guidelines stated in relevant legislation. See above.	
Based on the screening process please indicate if this policy should proceed to a full impact assessment or monitoring?	Full impact assessment	Monitoring ✓
	Please explain: Policy reflects national legislation, there are no concerns raised regarding any potential adverse impact upon individuals in relation to age, disability, gender, race, sexual orientation or religion/belief. There is no identified negative impact when considered in regard to any negative impact under current legislation.	

Appendix 2- Process of Decision Making

Stage 1:

The first stage in the process of decision making is to start from a presumption that the person has capacity and to help the person make the decision using whatever means are necessary or appropriate. Guidance on this is given at the Mental Capacity Act Code of Practice (Chapter 4).

Stage 2:

The next stage is to give consideration to whether or not there are doubts about the person's ability to make the decision in question due to an impairment of or disturbance in the person's mind or brain. Doubts as to the person's ability to make the decision may be due to their behaviour, actions or circumstances or because of concerns expressed by someone else.

If there are no doubts about the person's ability to make the decision then whichever decision the person makes is valid. If there are doubts as to the person's ability to make the decision, then an assessment of capacity should be carried out.

Stage 3- Assessing Capacity:

Assessment of capacity must not be based on assumptions or based on the person's age, appearance, condition or behaviour alone. Assessment should be in keeping with the Mental Capacity Act Code of Practice and the principles outlined in paragraph 9 of the Mental Capacity Act policy.

- Does the person understand information relevant to the decision to be made?
- Is the person able to retain the information?
- Is the person able to weight the information in balance?
- Is the person able to communicate their decision?

To meet the test of capacity the person needs to meet all four of the above requirements. Where the outcome of the assessment is such that the person is believed to have capacity, then they will be able to make the decision in what they see as their own best interests and whatever decision is made is valid, whether or not others believe that the decision is eccentric or unwise. A person may have the capacity to make some decision but not others. We must weigh up a person's capacity against the specific decision, at the time it needs to be made. Many factors may influence a person's ability to make true informed choices about their life.

Stage 4:

Where the outcome of the assessment is such that the person does not have capacity, consideration should be given as to whether or not the person's capacity is transient that is, that he or she is expected to regain capacity at some point. Consideration should then be given as to whether the decision can wait until capacity is regained. Those involved would need to consider the nature of the decision, the implications of waiting for the person to regain capacity, the nature of any risks and the need to act in the person's best interests.

Stage 5:

Stage five is implemented where an action has to be taken on behalf of a person who has been assessed as not having the capacity to make the particular decision.

A person can make plans for their future needs, should they become incapacitated. Those acting on behalf of a person who lacks capacity has a duty to consider if any such plans have been made which has a bearing on the decision to be made. See paragraphs 13 and 22 of the Mental Capacity Act policy for more guidance.

There may be a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA). An EPA only relates to the property and financial affairs of a person. An LPA may relate to property and financial affairs and/or health and personal welfare decisions.

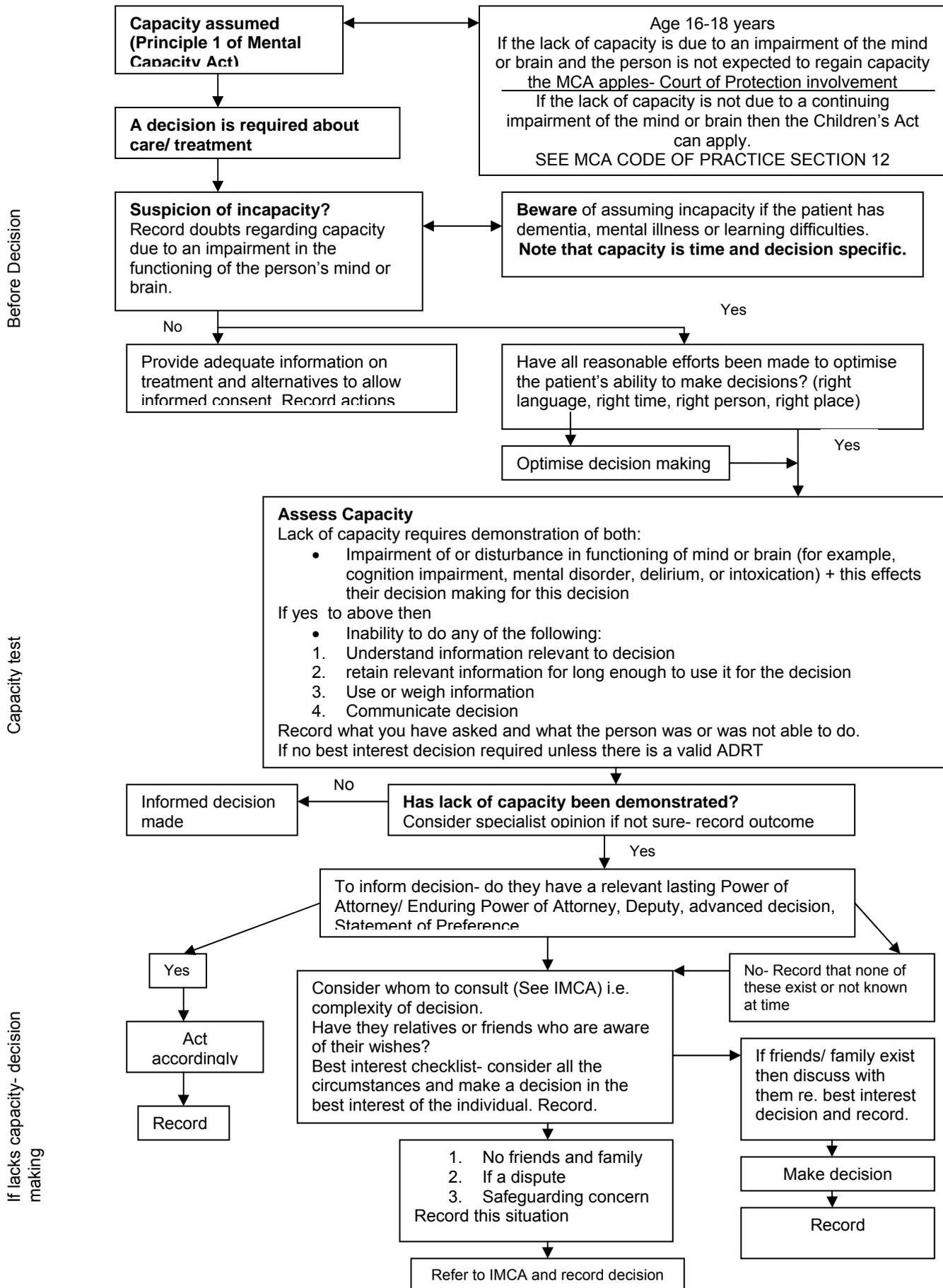
If an EPA or LPA exist, consideration must be given as to the nature of the power of attorney and how it relates to the particular decision. If the power of attorney is in relation to the decision to be made then those acting on behalf of the person who lacks capacity must be guided by the person with power of attorney, in deciding what action to take. The exact remit of the power of attorney should be considered. Where there is doubt about whether or not the person with the power of attorney is acting in the person's best interests, legal advice should be sought.

If a Deputy has been appointed by the Court of Protection, then the Deputy will advise on the action to be taken in the person's interests, as long as the decision is within the Deputy's remit.

If a person has made a valid and applicable advance decision to refuse treatment, the terms of this will be followed subject to the advice in Chapter 9 of the Code of Practice and Paragraph 13 of the Mental Capacity Act policy.

A person may have made a statement of wishes which must be taken into consideration when determining the actions to take in the person's best interests see chapter 9 of the Code of Practice and Paragraph 13 of the Mental Capacity Act Policy.

Appendix 3 - Flow Chart of how to decide whether or not a person aged 16 or over has capacity.



Appendix 4

Name:

DoB:

NHS No:

Mental Capacity Act 2005 Record of Assessment of Capacity (code of practice Chapter 4)		
1	Presumption of Capacity (Principle 1 of the Mental Capacity Act)	Guidance:
		<p>Starting from a presumption of capacity are there reasons to believe that the person has an impairment of, or disturbance in, the functioning of the person's mind or brain. For example because of a disability, condition or trauma. Please document</p> <p>This may be because of the person's behaviour, circumstances or because of concerns expressed by someone else: please indicate.</p>
2	Understanding Information about the decision to be made and helping the person make a decision. (Chapter 3 of the Code of Practice)	
	Details:	<p>What is the decision that needs to made?</p> <p>Consider how much information needs to be provided and in what way. Is help needed with specific cognitive problems?</p> <p>Is advice about how to communicate needed? (Eg family, friends, interpreter, Makaton, signer, speech, and language therapist.)Are there any cultural, ethnic or religious factors which need to be considered?</p> <p>Could the use of technology be helpful?</p> <p>Are there circumstances which may help the person make the decision, eg feeling at ease, location, presence of a friend or relative?</p> <p>Does the person understand what the likely consequences are? Do they understand the effects of deciding one way or another or not deciding?</p> <p>Have alternatives been explored and explained?</p> <p>Does the person understand the risks/ benefits of the decision?</p>

		<p>Does the person understand the reasons why the decision is needed?</p> <p>If capacity is variable, does the person understand what effect this in itself, will have on their decision?</p> <p>Can the decision wait until the person has capacity?</p>
3	Retaining Information	
	Details:	<p>The person will need to retain the information long enough to weigh it in balance and communicate the decision.</p> <p>Are there any tools which can help the person retain the information long enough to make the decision, eg notebooks, photographs, posters, videos, voice recordings etc.</p>
4	Weighing the Information in Balance	
	Details:	<p>Does the person have the ability to use, interpret, appreciate and assess the information whilst considering the decision?</p> <p>Does the person believe the information relevant to the decision in order to be able to weigh it in balance.</p> <p>Consider the nature of the impairment or disturbance the person suffers from, does this affect their ability to use the information about the decision.</p>
5	Communicating the Decision	
	Details:	<p>Consider how the person communicates. Communication may be by talking, signing, behaviour or any other means.</p> <p>Can anyone else, such as family or friends assist in helping the person communicate (often those closest to the person will be able to understand how the person communicates).</p>

		An ability to communicate articulately is not in itself, the defining factor in relation to capacity.
6	Consultation with Others	
	Details:	Details of who has been consulted, there relationship to the person and their views on the person's capacity.
7	Formulation of Outcome of Assessment of Capacity	
	Details:	On the balance of probabilities, is the outcome of the assessment that the person has capacity to make the decision or not. Record rationale, weighing all the evidence in balance.
8	Involvement of the Independent Mental Capacity Advocate (see Chapter 10 of the Code of Practice for more guidance)	
	Details:	The IMCA MUST be instructed where a person lacks capacity, is un-befriended (i.e. with no family or friends who are available and appropriate to support or represent them) and The decision is about providing, withholding or stopping serious medical treatment Or The decision is about placing a person in hospital for more than 28 days or in a care home for more than 8 weeks. Please see impact of Mental Health Act on IMCA services (Code of Practice Chapter 13) The IMCA MAY be instructed for a person who lacks capacity where there is a concern about adult protection (whether or not they are un-befriended) and for care reviews, where there is no one else to consult and the review concerns a potential change of care home.

Name of Assessor:

Title:

Date:

Appendix 5

THIS CARE PLAN IS GIVEN AS AN EXAMPLE ONLY AND IS NOT INTENDED TO OFFER AN EXAMPLE OF BEST PRACTICE. ITS PURPOSE IS TO ENCOURAGE CONSIDERATION OF THE PARTICULAR ASPECTS OF INDIVIDUAL PERSONS' CIRCUMSTANCES

Mrs A suffers from Alzheimer's Disease and lives in a residential home. Mrs A has variable capacity in that she sometimes has capacity to make decisions and sometimes she does not. Mrs A is visited often by her husband and she enjoys these visits, and appears calmer when he is with her.

1. Identified need

Mrs A has variable capacity to make decisions. This care plan aims to ensure Mrs A is helped to make decisions and where this is not possible to assist in the process of acting in Mrs A's best interests.

2. Action

- It is important to assume Mrs A has capacity to make decision unless it is clearly determined that she does not.
 - Mrs A should be helped to make decision for herself. Mrs A finds it easier to make decisions when she is in a calm environment and with someone she knows. When Mrs A needs to make important decisions, her husband should be present where possible to help Mrs A make the decision.
 - Where it is not practicable to have Mr A present, steps should be taken to ensure a member of staff who Mrs A knows is with Mrs A to explain in simple terms the decisions to be made.
 - Consideration should be given to whether or not a decision can wait until Mrs A has capacity to make the decision herself.
 - Where it appears Mrs A lacks capacity, decision taken must be in her best interests. On discussion with both Mrs A and her husband, the following have been identified as examples of Mrs A past wishes and feelings which should be considered (along with all other circumstance at the time)
- Mrs A has been lifelong vegetarian. If it is determined that she lacks capacity to decide what to eat it is likely that she would like to continue a vegetarian diet.
 - Mrs A is a Christian and has attended church on a Sunday most of her life. If it is determined Mrs A lacks capacity to decide whether or not she goes to a church service on Sundays, where possible Mrs A will be taken by a member of staff. Where this is not possible her local vicar has agreed to visit her in the home.
 - Mrs A has always enjoyed listening to the radio. She enjoys Radio 4 and where Mrs A appears to lack capacity to decide about the radio, it is appropriate to tune the radio to Radio 4.

- Mrs A has stated that she is more comfortable wearing trousers. Where Mrs A lacks capacity to decide what to wear, she should be helped to dress in trousers, unless this is inappropriate in the circumstances.
 - It is important that circumstances relating to each decision are considered each time a decision is required. It is not possible to anticipate all circumstances of all decisions within this care plan and those providing care and support to Mrs A must consider each decision on its own merits at the time.
3. Outcome: Mrs A is helped to make decisions and where this is not possible actions taken are in her best interests, in compliance with the Mental Capacity Act.

Example of care plan related to an Advance Refusal of treatment – This is an example only, care plans should reflect the individual circumstances of each case.

1. Identified Need:

Mrs A has made an advance refusal of treatment to be actioned if she lacks capacity to make decisions. The advance refusal specifically relates to life sustaining treatment and is considered valid as it is in writing, is witnessed, was written when it is believed Mrs A had capacity to make the decision and it is clear about the treatment it applies to. Mrs A has refused antibiotic treatment if she suffers from a chest infection and to cardio pulmonary resuscitation if cardiac arrest occurs as a direct or indirect result of a chest infection when she lacks capacity to make decisions for herself. This care plan aims to address the need to action the Advance Refusal in considered circumstances.

2. Actions: Mrs A Advance Refusal relates specifically to the administration of antibiotics for the treatment of a chest infection, and to CPR as a result of a chest infection, should she develop such an infection whilst incapacitated.

Should Mrs A develop a chest infection, consideration should be given to the following as to the applicability of the advance refusal.

- Is there any indication the Advance Refusal has been revoked? This could be due to Mrs A' behaviour or statements she has made regarding her future. Any such information should be discussed with the MDT and her husband as soon as is possible to enable the advance Refusal to be reviewed in light of any new information.
- Where there is no indication that Mrs A has revoked the Advance Refusal and she develops a chest infection, the circumstances of her condition should be considered. Mrs A has only refused antibiotics for a chest infection and CPR related to the effects of any such chest infection; any other infections or conditions should be treated appropriately and CPR or other emergency treatment will be given as is appropriate.

- If Mrs A has capacity to make a decision whilst she is suffering from a chest infection, her wishes and consent or otherwise at the time will be the consideration for treatment options NOT the advance refusal, as this only applies when she lack capacity to make the specific decision.
- Are there any advances in medical treatment or other circumstances regarding the care of Mrs A which she could not have known at the time the advance refusal was made and which may render the advance decision inapplicable at the time it needs to be actioned.

Any doubts about the ongoing validity or applicability of the advance refusal should be discussed in a timely manner with the Multi Disciplinary Team, in consultation with her husband and any other persons who are relevant friends or supporters of Mrs A.

3. Outcome: The advance refusal made by Mrs A will be actioned providing it remains valid and applicable in the individual circumstances at the time.

This care plan will be subject to regular review.

Appendix 6

Name:

DoB:

NHS No:

Mental Capacity Act 2005 Determination of Best Interests for people assessed as lacking Capacity (Chapter 5 of the Code of Practice)	
1	Can the decision wait until the person has regained capacity?
	<p>Is capacity variable or fluctuating in nature?</p> <p>Is it feasible to wait until the person regains capacity?</p>
2	Is there an advance decision?
	<p>Is the action required considered an emergency? Do not delay treatment unless it is already known there is a valid, applicable advance refusal.</p> <p>Is there an advance refusal of treatment? Is it valid? i.e. does it specify the treatment which is refused. If it is about life sustaining treatment, is it in writing, witnessed and clear that it concerns life sustaining treatment?</p> <p>Has it been subsequently withdrawn? Is there a subsequent LPA? Has the person behaved in a way inconsistent with the advance decision? Is it applicable in the present circumstances? Are there any specific circumstances in the advance decision? If so are those circumstances met?</p>

3	Is there a statement of wishes, feelings or beliefs	<p>Decision makers must take into account the person's previous wishes, feeling and beliefs when considering best interests. If possible these should be respected.</p> <p>These are useful in considering alternatives and lesser restrictive options.</p>
4	Is there a Lasting Power of Attorney?	<p>The Attorney will make the decision on behalf of the person lacks capacity. Check the details of the LPA. Health and welfare decisions can only be taken by an Attorney who has been given the relevant authority under a Personal Welfare LPA.</p>
5	Is there an IMCA?	<p>What are the views of the IMCA?</p> <p>Attach report if necessary.</p>
6	Encourage the person to participate as far as possible	<p>Help and support the person to be involved.</p> <p>What are their current views? Do these conflict with views of others?</p>

		Consider practicalities of carrying out a best interest decision in the absence of capacitated consent.
7	Views of the MDT	
		Which members of the MDT have been involved in determining best interests? What are their views?
8	Views of family, friends and supporters	
		Who has been consulted? What is their relationship? What are their views? What are the wider implications for the person who lacks capacity and their family, friends and supports?

9	Other circumstances	
		Detail any other circumstances which are relevant to consideration of best interest?
10	Formulation/ agreement of best interest and outcome	
		<p>What decision has been reached?</p> <p>What are the factors which contributed to this decision?</p> <p>Does the decision need to be subject to review at some point? If so when?</p>

Names and Contact details of contributors:

Name	Contact Details	Signature	Date
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Appendix 7

Kirklees and Wakefield Independent Mental Capacity Advocacy Service - a service run by the national mental-health charity Together, working in partnership with Kirklees and Wakefield Councils. This leaflet contains information for those wishing to refer someone to the Service.

The Service is based at:

21 King Street

Wakefield

WF1 2SR

Tel 01924 361050

Email kirkleeswakefieldimca@together-uk.org

Who is the Service for?

This Service covers the whole of the Kirklees and Wakefield local authority areas. The remit of services of this type is set out in the code of practice to the Mental Capacity Act 2005.

Independent Mental Capacity (IMC) Advocates can work with people who – for reasons such as learning disability, dementia, mental health problems or brain injury – are unable to make specific decisions about the following areas:

- Serious medical treatment;
- Accommodation changes that are for more than 28 days in hospital or eight weeks in a care home;
- Accommodation reviews;
- Adult protection.

(These issues are defined in more detail over the page.) The Mental Capacity Act 2005 code of practice also describes a two-stage test that should be carried out before an IMC Advocate is consulted, to show that the individual is unable to make the specific decision for themselves:

1. Firstly the lack of capacity can be for reasons including, but not limited to, a learning disability, dementia, mental health needs or acquired brain injury.

2. Secondly, the person must be *unable* to do one or more of the following in relation to the specific decision in question:

- understand information given to them;
- retain that information long enough to be able to make the decision;
- weigh up the information available to make the decision;
- communicate their decision.

So before a referral is made to the IMCA Service, the decision maker must determine whether or not the person has capacity to make the decision in question. Only if the person lacks capacity to make the specific decision

should the IMCA Service be involved. If, in the course of their advocacy, the IMC Advocate believes that the person in fact has capacity for the decision in question, they may request a re-assessment.

An IMC Advocate should usually only be involved if there are no family or friends that can appropriately represent the person. The exception is adult-protection issues when an IMC Advocate may be consulted regardless of whether or not there are family members or friends.

An IMC Advocate *cannot* be involved if there is:

- Someone else to consult about decisions who was previously 'nominated' by the person who now lacks capacity and who is able and willing to help;
- A deputy appointed by the court of protection (as long as the deputy is authorised to take the decision);
- A lasting power of attorney or an enduring power of attorney (unless they have been appointed only to deal with the person's property and affairs or the terms of the LPA do not cover the decision to be made).

The full Mental Capacity Act code of practice can be found at:

www.dca.gov.uk/menincap/legis.htm#codeofpractice

What kinds of issue can the Service help people with?

As we have said, the Mental Capacity Act says that IMC Advocates can provide advocacy for people around the following issues.

Serious medical treatment

The Mental Capacity Act regulations define 'serious medical treatment' as follows:

Treatment which involves providing, withdrawing or withholding treatment in circumstances where:

- A single treatment is being proposed and there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him
- A choice of treatments is available and the choice between them is finely balanced; or
- What is proposed would be likely to involve serious consequences for the patient.

People who are receiving treatment that is regulated under Part IV of the Mental Health Act 1983 do *not* qualify for the services of an IMC Advocate.

Changes in accommodation

The Service can help with any changes in someone's accommodation that will involve a stay of 28 days or more in hospital or eight weeks or more in a care home*. You should contact the Service whether the person is going into a care home or hospital for the first time or moving from one care home or hospital to another. However, if the change in accommodation is regulated under the Mental Health Act 1983 an IMC Advocate should *not* be involved.

People who fund, or will fund, their own residential care are eligible for the support of the IMCA Service if the local authority has assessed them and decided it has a duty to them. This includes placements made under Section 117 of the Mental Health Act 1983 and Section 21 or 29 of the National Assistance Act 1948.

Care reviews

An IMC Advocate should be contacted about a care review if the person whose situation is being reviewed lacks capacity; there is no other appropriate person to represent them; the decision-maker is satisfied that this would be of benefit to the person; they have been in the accommodation for more than 12 weeks; and the local authority or NHS arranged the original accommodation.

Adult protection

The IMCA Service should be contacted if protective measures are being put into place in relation to the protection of a vulnerable adult from abuse, if the person lacks capacity; and the decision-maker is satisfied that it would be of benefit to the person to do so.

The regulations apply equally to:

1. A person who has been abused
2. A person who has been neglected; and
3. A person who is alleged to be the abuser.

* The term 'care home' is not restricted to registered care homes. It covers a number of types of accommodation including nursing homes, care homes, ordinary housing, sheltered housing, housing association or registered social housing, hostel accommodation or private-sector housing provided by the local authority. See section 10.11 of the Mental Capacity Act code of practice for more information.

The role of the IMC Advocate

The IMC Advocate's role is to give an independent report on the person's current or past wishes, culture, beliefs and known needs, in order to help the professionals making the decision to ensure that they are working in the person's best interests.

The Advocate *does not make the decision*; the decision remains with the decision maker e.g. the doctor or social worker. But the Advocate will gather information about the person's wishes, values and circumstances, as well as identifying possible alternative courses of action, in order to inform the final decision. The Advocate will then present a report that must be taken into consideration by the decision maker.

IMC Advocates are entitled to:

1. See the person they are representing in private
2. Access to the person's medical and health records, and to take copies from these
3. Request further medical opinions.

These powers are explained in more detail below.

1 Access to service-users

Our Advocates are entitled to see the person they are representing in private. This means that they should be able to talk with the person in a private room where their conversation cannot be overheard or monitored. A bed on a ward with others around would *not* normally be acceptable. The only exceptions to this would be where:

- The individual refuses the option of going to a private room to talk
- It is not possible for the patient to leave their bed.

2 Access to medical and social-care records

IMC Advocates are entitled to see and, if necessary take copies from, the records of individuals they are representing, so long as the record-holder considers the information requested is relevant to the decision concerned. When an Advocate needs to access individual records, they will usually make this request to the decision-maker.

3 Obtaining further medical opinions

IMC Advocates are entitled to request further medical opinions if they believe this will help them to gain a clearer understanding of a patient's needs or of the treatments or outcomes that may be available.

Advocates requesting further medical opinion will make their request to the senior doctor responsible for the person's care. The request may be verbal initially but will be followed up in writing.

Making a referral to the Service

Referrals for individuals who meet the criteria should be made by the relevant decision-maker (though they may delegate the task). In the case of serious medical treatment, this will usually be the senior doctor responsible for the

patient's treatment. In the case of a change of accommodation decision, it will usually be the responsible social worker. Referral forms and leaflets about the Service can be obtained direct from the Service or downloaded from www.togetheruk.org/imca

Response time

People who need an IMC Advocate are likely to be facing a crisis. The Advocates will therefore work as quickly as possible to establish the wishes and needs of the person and the views of those who care for them. The referral form asks for timescales for decisions, please be as accurate as possible with these so that we can prioritise our response appropriately. The service aims to respond to all appropriate referrals as soon as possible. We will confirm receipt of your referral by email or post. We would expect to begin working on a referral within three working days.

Confidentiality

Please note:

- Information relating to people who use the Service will be treated in the strictest confidence and discussed only within the remit of the work of the IMCA Service with the appropriate members of staff.
- Information about staff will be treated in the strictest confidence and discussed only with other senior staff or line manager.

This list is not exhaustive and amendments and additions may be required in line with future policy changes.

Comments and complaints

Together welcomes feedback about the Service. To get in touch, or make a complaint about the Service, please contact.

The Service Manager at:
Kirklees and Wakefield IMCA Service
21 King Street
Wakefield
WF1 2SR
Tel 01924 361050
Email kirkleeswakefieldimca@together-uk.org

You can contact the Together Area Manager for this Service at:

Together
23 Queens Road
Barnsley
South Yorkshire
S71 1AN
Tel 01226 770895
Email am-kirkleeswakefieldimca@together-uk.org

You can also make a complaint about the Service through the relevant council's complaints procedure.

Appendix 8

Research Safeguards

Sections 30 – 34 of the act deal specifically with research but researchers should bear in mind the whole act when planning and undertaking research. The Act balances the right for people without capacity to benefit from properly conducted research with the need for strict safeguards and puts the interest of the research participant before the needs of science. The safeguards are:

Research must be approved by an “appropriate body” (normally a research Ethics Committee) to confirm the research is necessary, safe and cannot be done as effectively using people who have mental capacity.

The research must produce benefits to the person which outweighs any risk or burden to the participant, alternatively, if it is to derive new scientific knowledge, it must be of minimal risk to the participant and be carried out with minimal intrusion or interference with their rights. Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. The research must stop if the person shows any signs of resistance or indicates in any way that her or she does not wish to take part.

Transitional regulations covered research started before the Act where the person originally had capacity to consent, but later lost capacity before the end of the project (see Mental Capacity Act 2005 (Loss of Capacity During Research Project) (England) Regulations 2007)

Clinical trials of investigational medicinal products are not covered by the Mental Capacity Act because arrangements for participation of adults lacking in capacity are covered by separate legislation. Other research that does not require consent does not require specific arrangements for adults lacking capacity. This includes research involving only:

- anonymised data;
- anonymised human tissue obtained from the living;
- human tissue collected prior to 31 August 2006; or
- confidential patient information used under approval of the Secretary of State through the Patient Information Advisory Group (PIAG).

The Mental Capacity Act permits the removal of tissue from a person lacking capacity, if it is in their best interests. The tissue can be stored or used for research if:

- The research is to get information relevant to the health of another individual, and in the best interests of the person who lacks capacity;
- The research is a clinical trial of an investigational medicinal product; or
- The research is carried out under the Mental Capacity Act, meets the Act’s requirements and has ethical approval

Further information is available in a separate BMA guidance note: Human tissue legislation: guidance from the ethics department.

Appendix 9

The Mental Capacity Act and Children and Young People.

This information covers the areas relating to the few parts of the Act that may affect children under 16 years of age. It also explains the position of young people aged 16 and 17 years and the overlapping laws that affect them.

Within the MCA's Code of Practice, 'children' refers to people aged below 16. 'Young people' refers to people aged 16–17. This differs from the Children Act 1989 and the law more generally, where the term 'child' is used to refer to people aged under 18.

In this summary, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Children under 16

The Act does not generally apply to people under the age of 16 but there are two exceptions:-

- 1) The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions within Section 2(1)* of the Act and is likely to still lack capacity to make financial decisions when they reach the age of 18 (Section 18(3)).
- 2) Offences of ill treatment or wilful neglect of a person who lacks capacity within Section 2(1)* can also apply to victims younger than 16 (Section 44).

Young people aged 16–17 years

Most of the Act applies to young people aged 16–17 years, who may lack capacity within Section 2(1) (the lack of capacity to make a decision is caused by an impairment or disturbance that affects how the mind or brain works) to make specific decisions but there are three exceptions:-

- 1) Only people aged 18 and over can make a Lasting Power of Attorney
- 2) Only people aged 18 and over can make an advance decision to refuse medical treatment.
- 3) The Court of Protection may only make a statutory will (a will made on behalf of someone else) for a person aged 18 and over.

Care or treatment for young people aged 16–17

People carrying out acts in connection with the care or treatment of a young person aged 16–17 who lacks capacity to consent within Section 2(1) will generally have protection from liability (Section 5), as long as the person carrying out the act:

- has taken reasonable steps to establish that the young person lacks capacity;
- reasonably believes that the young person lacks capacity and that the
- act is in the young person's best interests, and

- follows the Act's principles.

When assessing the young person's best interests, the person providing care or treatment must consult those involved in the young person's care and anyone interested in their welfare – if it is practical and appropriate to do so. This may include the young person's parents. Care should be taken not to unlawfully breach the young person's right to confidentiality (see chapter 16 of the Code of Practice).

Nothing in Section 5 of the Act excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in carrying out the act.

Legal proceedings involving young people aged 16-17

Sometimes there will be disagreements about the care, treatment or welfare of a young person aged 16 or 17 who lacks capacity to make relevant decisions. Depending on the circumstances, the case may be heard in the family courts or the Court of Protection.

The Court of Protection may transfer a case to the family courts, and vice versa. This means that the choice of court will depend on what is appropriate in the particular circumstances of the case. For example, if the parents of a 17 year old who has profound learning difficulties cannot agree on the young person's residence or contact, it may be appropriate for the Court of Protection to deal with the disputed issues as any orders made under the Children Act 1989 will expire on the young person's 18th birthday.

Appendix 10

The Office of the Public Guardian

The Office of the Public Guardian will only provide information to statutory services. The Office of the Public Guardian will call back a person who has made an enquiry through the switchboard of the organisation for which the enquirer works, to ensure the caller is legitimate.

Office of the Public Guardian contact details:

PO Box 15118
Birmingham
B16 6GX

Phone lines are open Monday - Friday 9am - 5pm (Except Wednesday 10am - 5pm)

Phone number: 0300 456 0300 -
Fax number: 0870 739 5780