Tower Hamlets GP Care Group
Mental Capacity Act Policy

Date Issued	September 2017
Date to be reviewed	Periodically or if statutory changes are required
Title	Mental Capacity Act Policy
Supersedes	All previous Policies
This policy will impact on	All staff
Financial Implications	No change
Policy Area	Governance
Version No	2.0
Issued By	Quality, Safety & Governance Committee
Author	Phalguni Trivedi & Ruth Walters
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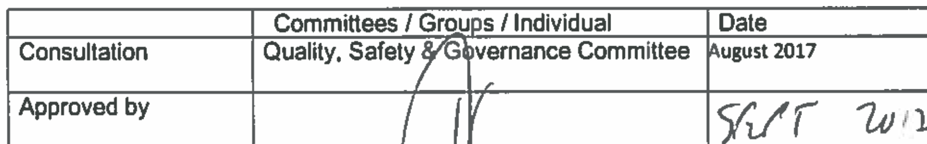
Approval Record

	Committees / Groups / Individual	Date
Consultation	Quality, Safety & Governance Committee	August 2017
Approved by		Sept 2017



1. Introduction

1.1 Mental Capacity is the ability to make a decision. Capacity can vary over time and by the decision to be made. The inability to make a decision could be caused by a variety of permanent or temporary conditions, for example, a stroke or brain injury, dementia, a mental health problem, a learning disability, confusion, drowsiness or unconsciousness because of an illness or the treatment for it; or due to alcohol or drug use/ misuse.

1.2 The Mental Capacity Act 2005 (MCA) clarifies a number of legal uncertainties and reformed and updated legislation where decisions needed to be made on behalf of people who lack mental capacity.

1.3 The MCA introduced statutory responsibilities and 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 years, living in England or Wales, who are unable to make all or some decisions for themselves. The MCA came fully into force on 1 October 2007. The Deprivation of Liberty Safeguards (DoLS) came into force on 1 April 2009.

1.4 Whilst the Act had significant implications for health and social care, it is also positive step towards protecting the rights of vulnerable people and safeguarding practitioners and clinicians from liability.

1.5 Principles of the Act
The whole Act is underpinned by 5 principles. These five statutory principles must underpin all acts carried out and decisions taken in relation to the Act. All professionals have a duty to comply with the Code of Practice, it also provides support and guidance for less formal carers (MCA Code of Practice)

1) Assume Capacity
Every adult has the right to make their own decisions if they have capacity to do so. A person must therefore always be assumed to have capacity unless it is established otherwise.

2) Practical steps to maximise decision making capacity
A person is not to be treated as unable to make a decision unless all practicable steps to help him\her to do so have been taken without success.

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3) Unwise decisions
A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision.

4) Best Interest
Any act done, or decision made, under the Mental Capacity Act (MCA) for or on behalf of a person who lacks capacity must be done or made in his\her best interests.

5) Least Restrictive Alternative
Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the persons rights and freedom of action.

1.6 The Act works on the basis that capacity is decision specific, which means capacity should be determined in relation to a specific decision a person is being asked to make. Someone can lack capacity to make some decisions where there are complex and significant issues to consider but may have the capacity to make other decisions.

1.7 The MCA allows people to express their preferences for care and treatment or to appoint a trusted person to make a decision on their behalf should they lack capacity in the future

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2. Aims and Objective

2.1 This policy applies to all directly and indirectlyemployed staff and other persons working within GPCG.

2.2 This policy guidance refers to the following:
'Mental Capacity Act' – Ministry of Justice, 2005 (The Act)
'Code of Practice to the Mental Capacity Act 2005 TSO 2007 (The Code of Practice)
'Code of Conduct' – Ministry of Justice, 2007
'Deprivation of Liberty Safeguards – Code of Practice, Ministry of Justice, 2007

2.3 Application of the Mental Capacity Act with our existing policies and processes

The Mental Capacity Act is a positive piece of legislation, with a focus on the empowerment of vulnerable people and an emphasis on their human rights. Rather than creating a whole new set of procedures and policies, the principles and values within the Act need to be embedded within Health care practice. The Act will underpin how we work with vulnerable people, who lack capacity at all stages of care management and all related assessment and care planning processes, confirming best practice. Our existing procedures will continue to be used, with some amendments in places to ensure we are meeting statutory requirements. Much of our work as a whole is with people who do have the capacity to make their own decisions. However, when we are working with someone who may lack capacity we need to take particular care to ensure that the principles and processes of the MCA are being applied within whichever procedural framework we are working.

3. Definitions

Mental Capacity Act 2005 (MCA) – The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose mental capacity. In relation to 16 & 17 year olds deemed to be Fraser competent, the principles set out in Section 1(1) of the MCA and listed in section 5.2 of this policy should be applied. However, it must also be considered that as defined by the Children Act 1989, 16 & 17 year olds are classified as children. If there are concerns of a safeguarding nature, theGPCG Safeguarding Children Policy should be referred to and acted upon in line with local authority safeguarding children procedures.

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Advance Decision to Refuse Treatment (ADRT) - A refusal of a future treatment made by someone who has the mental capacity to make that decision. It is legally binding if deemed to be both valid and applicable.

Independent Mental Capacity Advocate (IMCA) - An IMCA is someone instructed to support and represents a person who lacks capacity to make serious decisions.

Deprivation of Liberty (DoL) - A term used to describe the circumstances when a person's freedom is severely limited. Its meaning in practice is being defined through decisions from the courts.

4. Duties/Responsibilities

4.1 The Chief executive has accountability for ensuring the provision of high quality, safe and effective services within the GPCG and Executive Management Team are responsible for ratifying all policies and strategies.

4.2 Senior Leadership Team are responsible for the approval of all procedures/guidelines/protocols. Managers have the responsibility to ensure guidance and procedures are fully complied with.

4.3 All directors are responsible for the implementation of this policy into practice within their service areas and taking appropriate action should any breach of this policy arise

4.4 Operational leads
Responsible for:

- bringing to the attention of their staff the publication of this document
- providing evidence that the document has been cascaded within their team or department
- ensuring this document is effectively implemented
- ensuring that staff have the knowledge and skills to implement the policy and provide training where gaps are identified

4.5 Staff
Responsible for:

- adherence to this policy
- ensuring any training required is attended and kept up to date
- ensure any competencies required are maintained

- co-operating with the development and implementation of policies as part of their normal duties and responsibilities
- identifying the need for a change in policy as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards
- and local/national directives, and advising their line manager accordingly
- identifying training needs in respect of policies

Director of Quality & Assurance
Responsible for:

- quality checking all documents to ensure both statutory and GPCG requirements are met
- (this is to be carried out via stakeholder consultation)
- publishing approved/ratified/amended documents on shared drive and internet
- communicating newly approved/ratified/amended documents to Communications for publication in Team Brief

5. Assessment of Mental Capacity

5.1 Having mental capacity means that a person is able to make their own decisions.It should always be assumed that the person has the capacity to make the decision.
5.2 In many cases, the assessment of capacity is relatively straightforward and, with appropriate guidance, could and should be performed by the care-giver responsible for the particular decision in relation to which capacity is being assessed. In very complex cases, for example where the patient's decision-making capacity is borderline, appears to fluctuate rapidly or is - by reason of mental disorder - particularly difficult to assess, it may be necessary to obtain the opinion of a doctor or other senior professional. In these cases, it is good practice for the senior professional to assess capacity jointly with the care-giver in order that they can explain more fully the care decision to be made and the implications of a decision in either direction.

5.3 Where an individual is subject to multi-disciplinary care, the professional with greatest responsibility for the decision in relation to which capacity is being assessed (the 'decision-maker') should be the person who assesses capacity. Where this is in doubt agreement should be sought within the multi-disciplinary team.

5.4 Where a patient has been referred to the Court of Protection or other Court, either for a one-off decision or for the appointment of a Deputy, the Court will normally insist on an assessment of capacity being carried out by a Doctor

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6. When Mental Capacity should be assessed

6.1 Care and treatment, is often a matter not just of one-off treatment such as an operation or other medical intervention, but of on-going care over a period of years. The assessment of capacity must therefore be a continuous and ongoing process informed by the principle (see above 4.2 & 5.1) that a person is to be assumed to have capacity until it is established otherwise. Assessments of capacity must be time and decision specific as lack of capacity is not a static and permanent condition. All professionals involved in the provision of care and treatment must assure themselves either that the person continues to have capacity or that where they do not, the care and treatment given is necessary and in the person's best interests in compliance with the MCA code of practice (2007)

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6.2 It is helpful and best practice for the routine assessment of capacity to be noted in the patient records.

6.3 Occasions may arise when a patient faces an important decision, whether in relation to care and treatment or something arising from it or in relation to their financial affairs. Where there are any doubts about the ability of the patient to make the decision to give a valid consent to a treatment decision, e.g. because of borderline capacity or fluctuating capacity, a formal assessment of capacity must be carried out and documented.

6.4 It is not possible to list all the eventualities when a formal assessment of capacity is required and professional judgement must be exercised, however, the following represent some instances: -

- Informal admission to hospital.
- Consideration or use of Safeguarding Procedures.
- Serious medical treatment (as defined by the Mental Capacity Act 2005)
- Significant change of accommodation (as defined by the Mental Capacity Act 2005)
- Necessary breach of confidentiality (i.e. where personal information about the service user may be given to a third party).
- Important decision in relation to the management of finances, property or affairs.
- Any situation where consideration is being given to a referral under DoLS.

These may be supplemented by others and when in doubt staff should seek advice from their manager/senior colleague. In particular there may be some occasions when patients enter into sexual relationships where, in order to protect a potentially vulnerable person from abuse, staff should satisfy themselves through a formal assessment of capacity that the person has capacity to enter the relationship and is not being subject to abuse and/or sexual exploitation.

7. Demonstrating Decision-making Capacity

7.1 Mental Capacity is now given a statutory definition in the Mental Capacity Act. This states that to be considered as lacking capacity in relation to a decision a person must have some form of impairment of or disturbance in the functioning of the mind or brain which results in an inability to make the specific decision at that time.

7.2 The statutory test for capacity in relation to care and treatment or financial affairs is also now provided in the Mental Capacity Act Section 3 as follows:

- Understand the information relevant to the decision, including the purpose of any proposed course of action, the main benefits, risks and alternatives, and the consequences of refusing to follow the proposed course of action and of failing to make a decision.
- Retain that information for long enough to make a decision.
- Use or weigh that information as part of the process of making the decision.
- Communicate his or her decision, whether by speech, sign language or any other means.

7.3 Note that although 'believing the information given to them does not form an explicit part of the test of capacity as outlined above, a person who does not believe information that is self-evidently true is unlikely to be able to 'weigh' it in the balance 'as part of the process of making the decision' and is therefore likely to fail the test.

7.4 The MCA **does** allow for people to make 'unwise decisions' without automatically being assessed as lacking in capacity. It also allows people to make decisions based on their religion, cultural belief that may be contrary to their medical interests.

7.5 Note that the process of decision-making must be free from outside interference. A decision to receive a specific treatment that is the result of undue pressure or coercion is not freely made and any consent obtained in this way may be invalid

8. Determining an individual's best interests

8.1 All decisions and actions taken on behalf of a person who lacks capacity must be taken in the reasonable belief that they are in the person's best interests. This is one of the principles of the MCA

8.2 In determining what is in a person's best interests, regard should be had to medical and welfare issues, but also to the religious, cultural and ethical principles of the person. The following must be considered:

- Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question. (In which case all but urgent decisions can be deferred until the person regains capacity to make the decision themselves).

- The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence them if they had capacity.

- The need not only to allow but to encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her.

- The views of relatives, carers or other people involved whom it is appropriate and practical to consult about the person's wishes and feelings, and what would be in his or her best interests.

- Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action

- In the case of medical treatment, that treatment should be necessary to save life, prevent deterioration or ensure an improvement in the person's physical or mental health and should be consistent with a reasonable body of current medical opinion (the "Bolam" test).

In relation to 16 & 17 year olds deemed to be Fraser competent, the principles set out in Section 1(1) of the MCA and listed in section 5.2 of this policy should be applied. However, it must also be considered that as defined by the Children Act 1989, 16 & 17 year olds are classified as children. If there are concerns of a safeguarding nature, the GPCG Safeguarding Children Operational Policy should be referred to and acted upon in line with local authority safeguarding children procedures.

8.3 Best interest decisions cannot be made:

- Where the decision is in conflict with a valid Advance Decision
- For participation in research
- It is not possible to make a best-interests decision that someone should get married, divorced, enter into a sexual relation, have a child adopted, discharge parental responsibility or vote in an election

8.4 Where necessary Best Interests decisions should be documented on the Assessment of Mental Capacity Form

8.5 Safeguarding. In some cases it will be in the person's best interests to be referred to the safeguarding adult team as a vulnerable adult

In relation to 16 & 17 year olds deemed to be Fraser competent, the principles set out in Section 1(1) of the MCA and listed in section 5.2 of this policy should be applied. However, it must also be considered that as defined by the Children Act 1989, 16 & 17 year olds are classified as children. If there are concerns of a safeguarding nature, the GPCG Safeguarding Children Operational Policy should be referred to and acted upon in line with local authority safeguarding children procedures.

8.6 For further guidance see the 'best interest's checklist' at Section 4 of the MCA, from which the above is largely taken

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9. Referrals to Independent Mental Capacity Advocates (IMCAs)

9.1 A referral to an IMCA must be considered when the following apply:-

- A patient or other lacks capacity to make at least some important healthcare decisions for more than a purely short term period.
- The patient does not have relatives, carers or friends who can be consulted (this might include instances where there is a known relative, but they are not involved with or concerned about the patients care
- A decision needs to be made about serious medical treatment provided by the NHS and not covered by Part IV of the Mental Health Act 1983.
- A significant change of accommodation is proposed by a NHS body or Local Authority, for example to a residential or nursing home or to another hospital and this change is not taking place under the MHA 1983.

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10. Sharing

10.1 Where a patient lacks capacity to consent to information about themselves being shared, it may form part of a best interests decision that the information should be shared with others without their consent e.g. in Safeguarding Adult procedures.

10.2 Such others may include relatives, carers, and other professionals who have a need to know.

10.3 The results of the assessment of capacity, particularly in terms of a care plan, or the assessment itself, may thus be shared as necessary.

10.4 Where a patient retains capacity, personal information about them can normally only be shared with third parties with their consent.

11. Implementation process

11.1 Staff will be made aware of any new approved policies/procedures/guidelines via the team briefings. Quality, Safety & Governance team will be responsible for ensuring newly approved documents are sent to the communications team in order for them to insert into briefings and published on the THGPCG website.

11.2 All senior managers/heads of service/team leaders need to ensure new policies and procedures are placed on team meeting agendas for discussion. There is an expectation that the team leader will develop local systems to ensure their staff are instructed to read all relevant policies and to identify any outstanding training deficits.

12. Monitoring Process

12.1 Periodic audits of the assessment of capacity will be carried out, looking particularly at individual patient case notes, to examine whether this policy is being adhered to in practice.

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Equality Impact Assessment Tool for this Policy

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

Policy Name: Mental Capacity Act

Name of Assessor: Ruth Walters

		Yes/No/Possible/Not Applicable	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Religion or belief	No	
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems	No	
	Gender	No	
	Sexual Orientation	No	
	Age	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	No	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	