Adult Care Services

Hertfordshire Policy on Mental Capacity

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Contents

1. Introduction

The Mental Capacity Act 2005 (MCA) came into force in 2007 and provides a legal framework for the care, treatment and support of people aged 16 years and over, in England and Wales, who are unable to make some or all decisions for themselves. Anyone supporting people who lack capacity must have regard to the Mental Capacity Act. The MCA is accompanied by a statutory Code of Practice 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. As the Code has statutory force, all staff who are employed in health and social care are legally required to 'have regard' to the MCA Code of Practice.

This policy sets out the framework when assessing mental capacity and making best interest decisions. It sets out the responsibilities of all people in a caring role in respect of the Mental Capacity Act 2005 and the accompanying MCA Code of Practice.

Detailed guidance should be sought from the Mental Capacity Act Code of Practice, which this policy should be read in conjunction with.

2. Mental Capacity

2.1. The MCA sets out 5 statutory principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the MCA is done, or the 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 of the person's rights and freedom of action.

The principles aim to protect people who lack capacity and also help them take part in decisions that affect them to the best of their ability.

These principles **must** be considered and followed in every instance when working with someone who may lack capacity to make a decision or decisions for themselves.

2.2. Definition of lack of capacity

The MCA sets out three stages to test capacity:

- Stage 1 – the person is unable to make the decision, or there is reasonable doubt that they would struggle to make the decision which indicates the need for a capacity assessment
- Stage 2 – the person has an impairment of, or disturbance in the functioning of, the mind or brain
- Stage 3 - following on from Stage 2, the assessment must evidence that there is a causal link between the disturbance or impairment of the person's mind or brain and the person's inability to make the decision(s) in question.

“For the purpose of the Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain” (MCA, Section 2).

Stage 1 – Functional test

A person is unable to make a decision for themselves if they are unable:

- To understand the information relevant to the decision
- To retain that information
- To use or weigh that information as part of the process of making a decision, or
- To communicate their decision (whether by talking, using sign language or any other means)

A person is deemed to lack capacity if they are unable to meet one or more of these 4 steps.

Stage 2 – Diagnostic test

Evidence that a person has an impairment of the mind or brain or functioning that affects the way the mind or brain works. Examples include learning disability, dementia, delirium, brain injury etc. Please note that capacity is time specific and decision specific.

- “It does not matter whether the impairment or disturbance is permanent or temporary.
- “A lack of capacity cannot be established merely by reference to:
    - a person’s age or appearance, or
    - condition, or
    - an aspect of their behaviour, which might lead others to make unjustified assumptions about the person’s capacity.”

2.3. When to assess capacity

There should always be the assumption that a person has capacity to make the decision in question and assessors should take all practical steps to enable to person to make a decision. Decision makers must ensure that they allow, encourage and support people to make decisions for themselves wherever possible. However, if there is evidence to suggest that a person may lack capacity then an assessment of capacity should be carried out and enough information gathered to evidence and justify its outcome. The MCA makes it clear that any judgement about a person’s ability to make decisions must be on a decision-by-decision basis and be time specific.

2.4. Who should assess capacity

The person who assesses an individual’s capacity to make a decision (and a best interest decision where this is required) will usually be the person proposing the decision to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.

For example: If the decision was in relation to health treatment, then the appropriate person to assess capacity would be the health professional responsible for the treatment, such as a nurse, dentist, or doctor. For more complex decisions, it is likely that more formal assessments of capacity may be required to be completed.

2.5. Fluctuating capacity

Some people may at times be able to make their own decisions but have a mental health problem or other condition which affects their decision-making ability at other times.

Where there is fluctuating or temporary loss of capacity, an assessment of capacity has to be made at the time the decision has to be made. If it is possible, the decision should be delayed until the person has recovered and regained their capacity to make that specific decision. In emergency medical situations urgent decisions will have to be made and immediate action taken in the person's best interest. e.g., Heart attack, head injury etc. However, even in emergency situations, the person caring should try to communicate with the person and keep them informed of what is happening.

If an individual has been assessed as not having capacity to make a specific decision, this must be reviewed whenever new decisions need to be made or if there is a likelihood that the person may have regained capacity.

3. Best Interests

The term 'best interests' is not defined by the MCA. However, one of the key principles underpinning the MCA states that if a person has been assessed as lacking capacity, then any action taken or decisions made for, or on behalf of, that person must be made in their best interests. This principle is relevant for all aspects of any decision that is to be made on behalf of a person who lacks capacity to make that decision for themselves whilst also applying to anyone making a decision on that person's behalf. The exception to this rule is when a person (having previously had capacity) has made an advance decision to refuse medical treatment.

Chapter 5 of the Mental Capacity Act Code of Practice provides a checklist that should be followed when determining what is in an individual's best interests.

It is important that the person making the decision does not make assumptions based on:

- the person's age
- their appearance
- assumptions about their condition
- any aspect of their behaviour

The assessor **must**:

- Consider whether it is likely that the person will at some time have capacity in relation to the matter in question, **and** if it appears likely that they will, when that is likely to be.
- So far as reasonably practicable, permit and encourage the person to participate, or to improve their ability to participate, as fully as possible in any act done for them and any decision affecting them.

- Where the determination relates to life-sustaining treatment, in considering whether the treatment is in the best interests of the person concerned, the decision maker must not be motivated by a desire to bring about their death.
- Consider when they are unable to assess at this stage and consider delaying if appropriate, e.g. semi-conscious.

The assessor must consider, so far as is reasonably ascertainable:

- The person's past and present wishes and feelings (and in particular, any relevant written statement made by them when he had capacity), e.g., smoking. If a decision is contrary to the persons wishes, the assessor must be able to justify why this is the case.
- The beliefs and values that would be likely to influence their decision if they had capacity, e.g., vegetarianism, religious beliefs
- Any other factors that they would be likely to consider if they were able to do so, e.g., personal style, beauty regime.

The assessor must take into account, if it is practicable and appropriate to consult them as to what would be in the person's best interests, the views of:

- anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- anyone engaged in caring for the person or interested in their welfare,
- any Independent Mental Capacity Advocate (IMCA) appointed for the person
- any donee of a Lasting Power of Attorney (LPA) granted by the person, and
- any deputy appointed for the person by the court.

If the person has a deputy or Lasting Power of Attorney for health and welfare, the deputy or LPA would be the decision maker. Please refer to this practice note for further information.

4. Recording

When assessing a person's capacity, you are required to evidence how you have reached the decision that the person does or does not have capacity for the decision to be made. The assessor **must** demonstrate that they have applied the principles of the Mental Capacity Act and followed the Code of Practice when carrying out their assessment. The combined Hertfordshire Assessment of Capacity Form is designed to take you through the requirements of the Mental Capacity Act. Please refer to Appendix One (Mental Capacity Assessment) and Appendix Two (Best Interests Decision).

In some situations, it may be helpful to obtain a second opinion from another professional who has not been involved in the person's care.

If the person is found to lack capacity, then a best interests decision should be carried out.

You are required to evidence the process followed in making a best interests decision. This must be recorded. A combined Capacity and Best Interests Decisions form can be used for this. See form below.

5. Who is the decision maker?

The person who has to make the decision on behalf of the person lacking capacity is known as the decision maker. This will normally be the person responsible for the day-to-day care. Where a decision needs to be made about treatment, this could be the doctor or nurse.

6. What decisions cannot be made on behalf of another?

The following decisions cannot be made by the decision maker:

- consenting to marriage or civil partnership
- consenting to sexual relations
- consenting to divorce or dissolution of civil partnerships on 2 years separation
- consenting to a placement of a child for adoption by an adoption agency
- consenting to the making of an adoption order
- the discharge of parental responsibilities not relating to a child's property
- consenting to anything under the Human Fertilisation and Embryology Act
- voting in any election or referendum

7. Use of the Independent Mental Capacity Advocate (IMCA)

When a person lacks capacity and has nobody else who is appropriate and able to represent them or be consulted in the process of working out their best interests, an IMCA is appointed to provide this support in certain circumstances, for example, in situations relating to urgent medical treatment, moving home, and safeguarding.

An IMCA also provides independent safeguards for people who lack capacity. The IMCA makes representations about the person's wishes, feelings, beliefs and values at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity, if necessary.

The key functions of the IMCA are:

- representing and supporting the person who lacks capacity to participate as fully as possible in any relevant decision
- obtaining and evaluating information
- as far as possible, ascertaining the person's wishes and feelings, and beliefs and values that would be likely to influence the person if they had capacity
- ascertaining what alternative courses of action are available for the person
- obtaining a further medical opinion where treatment is proposed and the IMCA considers one should be obtained

- in certain circumstances, can challenge or provide assistance to challenge any relevant decision

7.1. When to refer

Under the MCA, a decision maker has a legal duty to instruct and consult an IMCA before making the decision (except in an emergency), in the following circumstances:

- the decision is about providing, withholding, or stopping serious medical treatment
- an NHS body or Local Authority is proposing to arrange accommodation for someone in hospital for longer than 28 days
- an NHS body or Local Authority is proposing to arrange accommodation for someone in a care home for longer than 8 weeks

AND the person without capacity has nobody else who is willing and appropriate to represent them or be consulted in the process of working out their best interests.

For these decisions, all local authorities and all health bodies **must** refer to an IMCA for anyone who lacks capacity and qualifies for the IMCA service.

7.2. Moves within health resources

Where a person moves to another bed within a health resource as part of their current episode of care, there will not need to be a referral to an IMCA regarding this move.

If the person moves to another health resource for rehabilitation, and it is planned that this episode of care will exceed 28 days (8 weeks in a care home), an IMCA **must** be instructed.

7.3. Involvement of an IMCA in Adult Safeguarding

The MCA provides Local Authorities and NHS bodies with powers to instruct an IMCA where protective measures are being put in place in relation to the protection of adults at risk from abuse – even if there are friends or family involved – if it is satisfied that it would be of benefit to the person to do so.

Although there is discretion to appoint an IMCA in these cases, there is a duty on every occasion to consider whether or not such an appointment is necessary.

All safeguarding strategy meetings should consider if a referral should be made to an IMCA. Further guidance is available in the Safeguarding Adults at Risk Policy.

The regulations apply equally to:

- An adult at risk who has been abused,
- An adult at risk who is the alleged abuser.

7.4. Involvement of an IMCA in care reviews

Local authorities and NHS bodies have the power to instruct an IMCA in care reviews if:

- the Local Authority or NHS body has arranged the accommodation
- the person whose accommodation is being reviewed lacks capacity; **and**
- there is no other appropriate person willing and able to be consulted.

In these circumstances in Hertfordshire, you may instruct an IMCA to represent the person concerned if it would be of benefit to the person to do so and if there is one or more of the following factors:

- an IMCA was involved in the initial placement
- an IMCA would have been involved but this was an emergency placement
- the person has lost capacity since being placed in accommodation
- there is disagreement between agencies and/or care provider on how best the person's needs can be met in the future.

The decision about whether or not to involve an IMCA and the reasons must be clearly recorded on the Hertfordshire Mental Capacity Assessment form.

7.5. IMCAs and independent advocates under the Care Act 2014

The power to instruct an IMCA under the MCA is separate to the duty placed on local authorities by the Care Act 2014 to provide an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in contributing to the process, and where there is no other appropriate adult to assist.

The local authority must meet its duties in relation to working with an IMCA provided under the MCA as well as those in relation to an advocate under the Care Act, although it is not required to provide two separate representatives for each role.

It may be the case that a person is entitled to an advocate under the Care Act and then, as the process continues, it is identified that there is a duty to provide an IMCA under the MCA. In these cases, the Care Act says that it is preferable that the advocate who is appointed in the first instance is qualified to act under the Mental Capacity Act (as an IMCA) and the Care Act, and that the commissioning arrangements enable this to occur.

7.6. Disagreement by the IMCA with the decision maker

An IMCA has the same rights to challenge a decision as anyone else involved in caring for, or interested in the welfare of, the person.

If a disagreement occurs, in the first instance, the IMCA should discuss with the decision maker the areas they disagree about and try to seek resolution. There should be involvement of the decision maker's line manager and the IMCA's line manager to try and determine a way forward. If however following these discussions

it is not possible to reach a mutually agreeable position then local procedures for settling disputes should be followed.

8. Access to records

Information on the person who lacks capacity is confidential. It is regulated by the Data Protection Act 1998, the common law duty of confidentiality, the Human Rights Act 1998 and the European Convention on Human Rights, Article 8. Detailed guidance on confidentiality and disclosure can be found in Chapters 4 and 16 of the Code of Practice. Before any records can be provided to a third party, the person will have to give permission for their records to be shared with other professionals. If it is deemed that the person lacks capacity, then a best interests decision about sharing their information will need to be made.

The Mental Capacity Act gives the IMCA the right to examine and take copies of any records that the person holding the record thinks are relevant. This is likely to include clinical records, care plans, social care assessment documentation or care home records. Only as much information as necessary should be provided.

9. Protection for staff providing care or treatment

The MCA provides legal protection from liability for carrying out actions in connection with the care and treatment of people who lack capacity to consent, provided that before taking the action you take reasonable steps to establish:

- whether the person lacks capacity to the matter in question
- when carrying out the act you reasonably believe the person lacks capacity
- that it would be in their best interests for the act to be done; and
- there is no advance decision prohibiting the act from occurring.

As a result, this means that if a person's capacity and best interests have not been assessed, no legal protection will be available. It is therefore imperative that all acts of decision making are clearly recorded to evidence that the decisions have been correctly reached if the decision was ever challenged.

This legal protection does not extend to restrictions that cumulatively amount to a deprivation of a person's liberty.

10. Criminal Offences

The Mental Capacity Act introduced the criminal offences of ill-treating or wilfully neglecting a person who lacks capacity to make relevant decisions. The offences may apply to:

- anyone caring for a person who lacks capacity - this includes family carers, health care and social care staff in hospital or care homes and those providing care in a person's home.
- an attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney, or

- a deputy appointed for the person by the court.

11. Deprivation of Liberty Safeguards (DoLS)

The MCA 2005 was amended in 2009 to include provisions regarding Deprivation of Liberty Safeguards to prevent breaches of the European Convention on Human Rights (ECHR). They provide legal protection through a system of assessments and authorisations for people that are or may become deprived of their liberty, within the meaning of Article 5 of the ECHR. The safeguards apply to anyone accommodated in a hospital or care home who has an impairment of the functioning of the mind or brain and is considered to lack the capacity to consent to the arrangements for their accommodation and care and treatment.

In March 2014 following a high court ruling P v Cheshire West & Chester Council; P & Q v Surrey County Council an “Acid Test” was laid down to determine whether a person is deprived of their liberty: -

- Lacks capacity and
- The person is under continuous supervision and control; and
- Not free to leave the care home or hospital.

The safeguards are to ensure that the best interests of the person are considered, and that no deprivation of a person’s liberty can be authorised except in accordance with the law, the safeguards state that in these circumstances the arrangements must be: -

- in the person’s best interests
- necessary to protect them from harm
- a proportionate response to the likelihood and seriousness of the harm
- the least restrictive available option for the person.

As well as in hospitals or care homes, deprivation of liberty can occur in living placements within the community for example in domestic settings. In these cases, an application to the Court of Protection would be required.

Further guidance on Deprivation of Liberty Safeguards can be found in the Hertfordshire DoLS policy.

12. Lasting Powers of Attorney

People over the age of 18 with capacity can formally appoint one or more people as Lasting Powers of Attorney (LPAs) to look after their personal welfare, and/or their property and affairs. This allows individuals to plan ahead for a time when they may not have capacity to make certain decisions and provides the LPA with the power to make decisions as if they were the person.

The person making the LPA is known in legal terms as the donor, and the power they are giving to another person (the donee) is the Lasting Power of Attorney. The person appointed is then called an attorney. The LPA gives the attorney the authority to make decisions on the donor’s behalf. Attorneys acting under an LPA have a legal

duty to have regard to the guidance in the MCA Code of Practice and act in the individual's best interests. Evidence of LPA registration documentation should be seen, and a copy taken.

An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. An unregistered LPA does not give the attorney any legal powers to make a decision for the donor. The donor can register the LPA while they still have capacity, or the attorney can apply to register the LPA at any time. Staff can check the register on the OPG website if they are unsure about the validity of an LPA.

If a person has an LPA then an IMCA would generally not be appointed. The donee with LPA can only make decisions when the person lacks capacity. They must also make all decisions in accordance with the person's best interest.

Evidence **must** be given to show registration of LPA documentation. This should be checked by the person caring for the client. If this is not offered this should also be questioned.

Details of the application forms and supporting documents can be found on the OPG website.

13. Certification of the LPA

Staff may be approached by individuals they are working with to help support them in the process of completing the LPA form or to certify the form. Staff should explain that their contract of employment does not cover this and that those wanting support with the LPA process should seek advice from a solicitor or from the local Citizens Advice Bureau.

All deputies are supervised by the Office of the Public Guardian.

14. Enduring Powers of Attorney

Before the MCA came into force, Enduring Power of Attorneys relating to financial decisions could be made. Any EPAs made before 1st October 2007 remain valid; however, no new EPAs can be donated since the implementation of the MCA. Details of the law and policies covering EPAs can be found at the Office of the Public Guardian.

15. Role of the Court of Protection and court appointed deputies

15.1. Court of Protection

The Court of Protection has powers to:

- make declaration about whether or not a person has capacity to make a particular decision
- make decision on serious issues about health care and treatment
- make decisions about the property and financial affairs of a person who lacks capacity

- appoint deputies to have an ongoing authority to make decisions
- make decisions in relation to LPAs and EPAs.

15.2. Court appointed deputies

Deputies can be appointed by the Court of Protection for property and affairs and / or personal welfare decisions when a person lacks capacity to make the decisions for themselves. Deputies must have regard to the MCA Code of Practice and act in the person's best interests. Anyone can be appointed as a deputy provided that they are suitable and willing to be appointed. Where a person already lacks capacity but requires a decision maker, an application can be made to the Court of Protection to appoint a Deputy to make decisions.

15.3. Court of Protection Visitors

A Court of Protection Visitor provides independent advice and reports to the Court of Protection and the Office of Public Guardian. There are two types of visitors, General Visitors and Special Visitors. Special Visitors are registered medical practitioners with relevant expertise.

16. Advance decision to refuse treatment

An advance decision enables someone aged 18 and over and with capacity to clearly state the medical treatment they would want to refuse and the circumstances in which they would not want treatment. An Advance Decision is the ability to refuse treatment if you lose the ability to, or are not able to, communicate your choice yourself at the time the treatment is required.

The advance decision does not have to be in writing (although this is advisable) and the care provider should record on the person's record if they are aware of the existence of an advance decision and where this is kept. Practitioners should note that advance decisions regarding life sustaining treatment and Do Not Attempt to Resuscitate are required to be in writing and witnessed.

An advance decision to refuse treatment **must** be valid and applicable to the current circumstances and decisions to be made. A valid advance decision should be treated the same as a decision made by someone with capacity. The decision must be followed.

If the advance decision refuses life-sustaining treatment, it must:

- be in writing
- be signed and witnessed, and
- state clearly that the decision should be applied even if life is at risk.

17. Children and young people

Details of how the MCA applies to young people aged 16 -17 and the overlap between the MCA and the Children Act 1989's legislation, can be found in the Code of Practice Chapter 12.

Young people aged 16–17 years

Most of the MCA applies to young people aged 16–17 years, who may lack capacity within

Section 2(1) * 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 for a person aged 18 and over.

Decisions about a young person's capacity or best interests should be made in the same way as with adults.

18. Relationship between the MCA and the Mental Health Act (MHA)

Details of the interface between the MHA and the MCA can be found in Chapter 13 of the Mental Health Act 1983 Code of Practice update 2015.

In essence the MCA is designed to protect and assist people who lack the necessary capacity to make decisions about their care and treatment. In contrast, the MHA is used to protect people who require treatment for serious mental disorders and are deemed to be of a sufficient risk to themselves or others.

It can sometimes be difficult to determine which piece of legislation is the most appropriate to use and so a sound understanding and application of the principles and provisions of the Mental Health Act (MHA), Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and of the common law relating to consent, is essential to enable decision-makers to fulfil their legal responsibilities and to safeguard their patients' rights under the European Convention on Human Rights (ECHR).

19. Settling disputes and disagreements

It is important that disagreements are settled before they become serious disputes. Emphasis should be on early resolution, to try and prevent the need for referral to the Court of Protection.

Professionals should involve their line manager at an early stage. Legal advice may need to be sought. People being cared for and their families may make use of the appropriate health trust or social care complaints policy. The Code of Practice offers some practical advice, see Chapter 15.