University Hospitals of Morecambe Bay NHS Foundation Trust

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Ratified By: Procedural Documents and Information Leaflet Group Chairman's Action	**Date:** 07/07/2015
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Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 1-7 Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Reference Check Completed by……Frances Sim……..Date……15.7.15…….

To be completed by Library and Knowledge Services Staff

CONTENTS

BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

The Mental Capacity Act 2005 (MCA 2005)[1] gives statutory rights to patients regarding the way that Trust staff make decisions that affect their welfare and treatment. The MCA 2005[1] also provides protection to Trust staff when performing tasks in the care and treatment of patients.

2. PURPOSE

- The Mental Capacity Act 2005[1], (MCA) covering England and Wales, applies to all people aged 16 and over and provides a statutory framework for people who lack capacity to make decisions for themselves or who have capacity and want to make provision for a time when they may lack capacity in the future. The legal framework is supported by the Mental Capacity Act 2005[1] Code of Practice (DCA 2007)[2], which provides guidance and information about how the Act works in practice.
- This policy requires changes to working practice to ensure the requirements of the Act are embedded into policy, procedure, every day practice and service specific contracts.
- This policy provides a framework for all staff assessing capacity and aims to ensure the principles of the Mental Capacity Act 2005[1] and its supporting code of practice are upheld when making decisions.

3. SCOPE

This policy applies to all staff employed by University Hospitals of Morecambe Bay NHS Foundation Trust including anyone who holds honorary contracts or who has been subcontracted by the Trust.

The Mental Capacity Act 2005[1] sets out who can and how to make decisions relating to care and treatment for those who lack capacity to make such decisions. The Act covers decisions relating to finance, social care, medical care and treatment, research, everyday living decisions, as well as planning for the future.

It does not include decisions covered by other statute such as treatment under the Mental Health Act marriage/civil partnership, divorce, sexual relationships, tenancy agreements etc. (MCA Code of Practice, Chapter 1, Section 1.10)[2].

4. POLICY

4.1 Responsibilities

4.1.1 Trust Board

The Trust Board have responsibility for the quality of service provided to the populations served.

The Trust Board responsibilities are delegated to the Director of Nursing who will ensure there are systems and processes in place for the implementation of the Act; this policy and procedures in relation to the Deprivation of Liberty Safeguards[3]. Mental Capacity Act implementation is reported within the safeguarding quarterly and annual report. The Director of Nursing will be supported by other executives and senior managers and follow

best endeavours to:

- Ensure that all performance and quality monitoring documentation is clear about the Trust's expectation for systems, processes and good practice to be compliant with the Act.
- Ensure that incident, complaint and disciplinary reporting systems provide a structure for regular thematic reporting of events of a nature that relate to the Act to the Director of Nursing. They will also ensure the support of their department to the collection of information for governance and provide the support of the audit department for the measuring of compliance
- Proactively promote the implementation of the 5 principles of the Mental Capacity Act 2005[1] as outlined below in all services.
- Ensure the robust infrastructure for the development and maintenance of staff knowledge and skills in matters of mental capacity and deprivation of liberty.

4.1.2 Senior Managers

Senior Managers will proactively support the implementation of this policy. In addition they will identify and support the development of local resources to enable capacity for decision making and support resources for a variety of communication methods such as easy read information, audio and video based information and other pictorial resources.

4.1.3 All Staff

All staff have a statutory obligation to comply with the Act. It is each individual's responsibility to familiarise themselves with the Act, how it applies to their area of work and seek relevant information and advice where necessary. All staff are responsible for ensuring any concerns or practical factors that hinder/oppose the implementation of this policy, which have not been possible
to resolve or overcome at local level, are reported through the network governance structures.

4.2 Principles

Section 1 of the Mental Capacity Act (2005)[1] sets out five principles designed to emphasise the fundamental concepts of the Act. All staff will comply with their statutory duty to implement the Mental Capacity Act (2005)[1] by adhering to the five principles.

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help have been taken without success.
- A person is not to be treated as unable to make a decision merely because it is 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 best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

When implementing the five principles in practice, all staff will work in partnership with the person, other agencies, informal carers, family and friends, and ensure their documentation

reflects how the Act has been implemented.

For further details staff are referred to the following web addresses:

The Mental Capacity Act Code of Practice[2]:
http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

The Mental Capacity Act Deprivation of Liberty Safeguards Code of Practice[2]:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm

4.3 Naming a Decision Maker

The name of the decision maker must be recorded. This would be the person most appropriate to the decision being made or responsible for the course of action under consideration. This person is responsible for ensuring the Mental Capacity Act (2005)[1] is followed. The process of arriving at a decision of 'Best Interests', the information that informed the decision (including an options appraisal), those involved in the decision and the decision made must be clearly recorded in the patient / client / service user record.

4.4 Reasonable Belief

In most circumstances, it is sufficient for the person assessing capacity to hold a reasonable belief that the person lacks capacity to make a specific decision. Absolute certainty is not required, however the assessor would need to be able to give objective reasons for this belief and evidence it through comprehensive record keeping. The code of practice lays out the nature of decisions that can be made with only a reasonable belief of a lack of capacity. Significant decisions, decisions relating to restraint as defined by the Act and decisions that have serious consequences must have a more considered and detailed assessment of capacity

4.5 Enabling People to Make Decisions

Staff will be flexible, person-centred and responsive to each individual's communication needs. This can be achieved by:

- Providing all information relevant to the decision, including information about any choice or alternatives.
- Communicating in a way that the person is most likely to understand.
- Providing information in a format that is likely to be understood by the person, not just relying on written or spoken word, e.g. the use of easy read guides, photographs, symbols, role play and social stories.
- Making the person feel at ease and considering what is likely to be the most conducive time and location for them to make the decision.

Supporting the person and considering if others can help them to understand information or make a choice.

4.6 Capacity Assessment

A person lacks capacity in relation to a matter if at the material time he or she is unable to make a decision for themselves in relation to the matter because of an impairment of, or a

disturbance in the functioning of, the mind or brain. 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
- Assumptions about their condition or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.

Any question whether a person lacks capacity must be decided on the balance of probabilities

4.7 Assessing Capacity

Within the Mental Capacity Act (2005)[1] the term capacity relates to the person's ability to consent to or refuse care or treatment.

A judgement of lack of capacity cannot be made on the basis of a person's age, appearance, diagnosis or any aspect of the behaviour.

The Act provides a two stage test for assessing a persons' capacity, and this must be used for each individual decision to be made. Staff will have regard to the burden on them to prove a lack of capacity not on the patient/client/service user to prove they have capacity.

The assessment must:

- Relate to a specific defined decision
- Be undertaken at a time relevant to the decision
- Be clearly documented in the care record

It is useful to consider the key aspects required to be understood, retained and weighed for the decision in question and the person in question before embarking on the assessment of capacity. This provides a person specific/centred benchmark against which to assess capacity.

4.8 Who Can Assess Mental Capacity

Anyone can assess mental capacity. The decision as to who is the best person to assess capacity is dependent on the decision to be made. The Act requires a person to be named as the decision maker – this person is responsible for ensuring the Act's requirements are followed and documented. It is expected that the person responsible for the delivery of the care or treatment in question will complete the capacity assessment.

The depth of the capacity assessment will depend on the nature and impact of the decision being made. For significant decisions a more detailed assessment of capacity will be required. The opinion of others may assist in a finding of capacity/incapacity, but the decision as to whether someone has or lacks capacity must be taken by the 'named decision-maker'.

In some circumstances it may be advisable to have an assessment of capacity to support risk assessment and risk management plans for unwise decisions

Please refer to the Deciding Right P53 document for guidance of capacity

assessment completion via, Palliative Care and End of Life Care. Available on the Trusts Intranet page.

4.9 Documenting an Assessment of Capacity

The minimum expectation is that the information relating to the stages and sub tests of a capacity assessment are entered as 'free text' into the relevant clinical record (electronic and/or paper based). The clinical record should evidence that the staff member has identified the impairment or disturbance in the functioning of the patient/client/service user's mind or brain and assessed the ability to understand, retain and weigh up the information relevant to the specific decision to be made and communicate their decision by any means.

For significant decisions on such matters as serious medical treatment (see later), restraint, accommodation and financial decisions it is recommended these be recorded on specific documentation.

Services may decide to integrate the Acts requirements into existing or locally developed formats. Where this is the case the documentation format developed must be approved as meeting the Acts requirements by a mental capacity Implementation Lead.

Where the record of assessment (and subsequent Best Interests Decision) explicitly and adequately demonstrates that the requirements of the Act have been followed, the decision maker is protected from liability. This information may be used in dispute mediation; court processes or investigations.

4.10 Consent to Examination or Treatment

When an adult patient/client/service user lacks mental capacity to give valid consent to a specific decision, no one else can give consent on their behalf unless they have powers to make welfare decisions by being a registered Lasting Power of Attorney for Health and Welfare or a Court Appointed Deputy for Health and Welfare. Evidence must be seen and a copy kept on the clinical record to support the claim of power to act on behalf of an adult who lacks capacity

4.11 Best Interests

4.11.1 Best Interests Decisions

When a person is assessed as lacking capacity to consent to or refuse care and/or treatment a 'best interests' decision must be made by the decision maker (or an application to the Court of Protection for a court order/ declaration). The Mental Capacity Act (2005)[1] sets out a statutory checklist of factors that must be considered for any decision made in best interests of the patient / client / service user.

The decision maker must evidence through contemporaneous record keeping how they came to the decision in best interests evidencing the alternatives to the proposed treatment including the risks and benefits of each available option.

It is a minimum requirement that the decision maker documents day to day best interest decisions within the patient / client /service user documentation / care record. For significant decisions on such matters as serious medical treatment (see later), restraint, accommodation and financial decisions it is recommended these be recorded in the patient's medical record and Capacity Assessment & Best Interest record form.

As with assessments of capacity, each best interest decision must be decision specific, and evidenced through care/support planning documentation.

Please refer to the Deciding Right P53 document for guidance of best interest assessment completion via, Palliative Care and End of Life Care. Available on the Trusts Intranet page.

4.11.2 Disputed Best Interests Decisions

The decision maker should seek to avoid disputes occurring by having a clear and transparent process that includes good communication with all parties. However in a small number of cases disputes will still be evident due to conflicting views.

In those cases the determining factor must always be the best interests of the person who lacks capacity. Ultimately the decision maker is responsible for making the best interests decision. However others, such as family members, may consider themselves to be the person best placed to be the decision maker. Where agreement cannot be reached, local mediation should be sought. In some circumstances it will be advisable to make an application to the Court of Protection for a declaration.

The decision maker can only consider information and circumstances that they are aware of having followed the statutory checklist. As such they must be conscious that their decision is based on specific information available at the time the decision was made. Further information may come to light through the challenge / dispute and the decision maker in these circumstances should revisit their balance table/options appraisal and reconsider their decision.

In circumstances where the decision has been implemented, providing the decision maker can evidence that the requirements of the Mental Capacity Act (2005)[1] had been complied with and they acted reasonably they will be protected from liability by The Act. This highlights the importance of good contemporaneous health record keeping.

4.12 Restraint

Use of restraint under the Mental Capacity Act (2005)[1] is permitted where it can be evidenced that it is necessary for the purpose of keeping the individual patient/client/service user safe from harm and proportionate to the harm likely.

Note: If the use of restraint is for the purpose of protecting others the framework of the Mental Capacity Act (2005)[1] is not appropriate and criminal and common law frameworks should be used which also require evidence of reasonableness; potential for harm, necessity to use such techniques and proportionality of use.
Note: Staff working with individuals who are being treated under the Mental Health Act (2007)[3] should refer to the statute within the Mental Health Act (2007)[3] that relates to the use of restraint.

The Mental Capacity Act (2005)[1] defines restraint as:

- use for - or threaten to use force - to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.

From this definition, most practitioners are likely to use or recommend some form of

restraint in every day practice; (an example may be holding a person's arm to prevent needle stick injury during administration of an injection or recommending the use of a lap strap on a wheelchair and the use of covert medication techniques for a patient who lacks capacity).

4.13 When Should Restraint be Used

Restraint can only be used under the provisions of The Act for people who lack capacity and where there is reasonable belief that it is necessary to prevent harm to the patient/client/service user and the nature and duration of the restraint used is a proportionate response to the likelihood and seriousness of that harm.

Any proposed/planned use of restraint must be clearly documented using the best interest process to evidence the nature and purpose of the proposed restraint, any alternatives and why it is required in the best interests of the patient / client / service user. The use of restraint must be clearly documented in the patient/client/service user's care record.

Although the Act permits the use of restraint when necessary under the above conditions, it does not permit any act that would deprive a person of their liberty within the meaning of Article 5(1) of the European Convention on Human Rights. Deprivation of Liberty must be authorised through a legal process to retain protection from liability under the provision of the Mental Capacity Act.

Some service areas will have specific procedures for the use of restraint e.g. Intensive Care Unit / Cardiac Intensive Care Unit.

4.14 Statutory Duties within the Mental Capacity Act 2005[1]

4.14.1 Independent Mental Capacity Advocate (IMCA)

The IMCA service provides independent safeguards for people who lack capacity to make specific important decisions. The IMCA does not assess capacity or make best interests decisions but will gather information to support the decision maker and check the quality of the process used by the decision maker. IMCA's have a statutory right of access to records relating to the decision being made, any request for access to relevant information should not be delayed. A record entry must be made that indicates an IMCA's access to records and what information they were permitted to access.

Urgent treatment would be given out of hours even if the need for an IMCA was indicated. This would be performed in the best interest of the person, reviewed at the earliest opportunity, documented in the case note and referral made to the IMCA as a matter of routine.

4.15 When should a referral be made?

There is a statutory duty on the decision maker to refer a patient/client/service user to the IMCA service when the person lacks capacity for that specific decision, they are un-befriended and the proposed decision is in relation to:

- Serious Medical Treatment
- A proposed stay in hospital longer than 28 days (including intermediate care).
- A proposed accommodation move for longer than 8 weeks.

There is a local duty on the decision maker to refer a patient/client /service user to the IMCA service when the person lacks capacity for that specific decision, they are un-befriended and the proposed decision relates to

- A care review involving an accommodation decision

There is a local duty on the decision maker to refer to the IMCA service a person who lacks capacity when a safeguarding concern is raised and those friends/relatives to be consulted are either the alleged perpetrators of the abuse or considered not be acting in the person's best interests.

In some circumstances where there is clear evidence that the person is befriended, but those individuals are not suitable to consult with. The IMCA service can use their discretion to become involved e.g. very elderly relatives who may be significantly unwell

4.16 What Does the Act Mean by Serious Medical Treatment?

The Mental Capacity Act (2005)[1] defines serious medical treatment as giving new treatment, stopping treatment that has started or withholding treatment where there is:

- a fine balance between the likely benefits and burdens to the patient/client/service user and the risks involved,
- a decision between the choice of treatments is finely balanced or
- what is proposed is likely to have serious consequences to the patient/client/service user.

Serious consequences are those which could have a serious impact on the patient/client/service user, either from the effects of the treatment or its wider implications. This may include treatments which:

- cause serious and prolonged pain distress or side effects
- have potentially major consequences for the patient/client/service user
- have a serious impact on the patient/client/service user's future life choices.

4.17 Lasting Power of Attorney

Lasting Powers of Attorney were introduced with the Mental Capacity Act. People aged 18 or over with capacity (donor) have the ability to formally nominate another adult(s) to be their decision maker (donee(s)) if/when they lose capacity to make decisions. The donor can stipulate what decisions can be made by the donee(s).
There are two types of Lasting Power of Attorney that a person with capacity over the age of 18 can appoint.

- property and affairs including finance decisions and
- personal welfare decisions including health decisions.

The power of the donee(s) to act as a personal welfare attorney only commences when the donor has been deemed as lacking capacity to make a specific decision.

For a Lasting Power of Attorney to be valid, it must be registered with the Office of the Public Guardian. (Please refer to Mental Capacity Act (2005)1 Code of Practice (DCA 2007)2, chapter 7 for further information).

Any decision made by a donee with a registered Lasting Power of Attorney is legally valid

where the attorney is acting in the person's best interests in accordance with the Code of Practice.

Staff must check the validity of the donee's powers, and retain a copy of a person's Lasting Power of Attorney on the clinical file. It would also be helpful to notify other staff / services involved in the person's care and treatment and where appropriate make available copies of the relevant documentation.

Attorneys have a statutory obligation to comply with the Act and its code of practice. Attorneys not doing so can be displaced by the Public Guardian.

Prior to the introduction of the Act, Enduring Powers of Attorney could be appointed for property and financial decisions. Any Enduring Powers of Attorney made prior to 2007 remain valid for property and finance decisions only.

4.18 Court Appointed Deputy

In some circumstances when a person lacks capacity to appoint a Lasting Power of Attorney, and on-going decisions are required the Court of Protection may appoint a deputy to make specific decisions. Court appointed deputies make decisions that are as valid as those made by a person with capacity. The Court of Protection will stipulate what decisions can be made by the deputy.

In the majority of cases, the court appointed deputy is likely to be a family member or a person who knows the individual well, but in some cases the court can decide to appoint a deputy who is independent from the family. (For further information relating to court appointed deputies refer to Mental Capacity Act (2005) Code of Practice (DCA 2007)[2], chapter 8). Staff must check the powers of any court appointed deputy and retain a copy of the direction of the court on the clinical record where this is enacted in relation to care and treatment. It would also be useful to inform other staff/services involved with the person's care and provide copies of the relevant documentation.

4.19 Advance Decisions to Refuse Treatment

The Mental Capacity Act (2005)[1] introduced the right for someone with capacity over the age of 18 to make an advance decision to refuse treatment. Many advance decisions do not have to be in writing, but the person needs to be specific about the treatment they are wanting to refuse in advance and the circumstances that refusal would relate to.

If the patient/client/service user wishes to make an advance decision to refuse life sustaining treatment it must be in writing; signed and witnessed. It must contain a statement indicating it is to apply even if life is at risk. (For further information please refer to Mental Capacity Act (2005) Code of Practice (DCA 2007)[2], chapter 9).

Staff are required to establish the validity and reliability of any advance decision. Those that are both valid and reliable must be complied with. A copy of the advanced decision should be retained on the clinical record. It would be helpful to advise others involved in the person's care of the advance decision and provide copies of any relevant documentation.

4.20 Court of Protection

The Court of Protection has jurisdiction relating to the MCA 2005[1] and is the final arbiter for capacity matters. It has its own procedures and nominated judges.

MCA 2005[1] states that the Court of Protection will have the same powers as the High Court. This gives it comprehensive jurisdiction over the health, welfare and financial affairs of people who lack capacity.

The court of protection must be consulted if

- There is a dispute regarding a Lasting Power of Attorney
- There is a need to appoint a deputy to make a decision on a person's behalf
- It is necessary to make a declaration on whether an act done or which is proposed to be done regarding a person is lawful
- It is necessary to make a declaration on whether a person has the capacity to make a particular decision
- The court must be consulted about some specific healthcare and treatment decisions as listed in section 8.18 of the code of practise

The MCA 2005[1] provides for the appointment of Deputies (see 4.9) by the Court of Protection where the Court cannot make a one-off decision to determine an issue. However, it is important to be aware that the powers of Deputies are restricted e.g. Deputies cannot act if a person can act for him or her self.

Any referral to the Court of Protection should be discussed in advance with the Trust Legal Department. Please contact Ranu Rowan Manager Legal Services, ext 46652

Any legal advice out of hours should be directed to the Duty Manager.

The Court of Protection Rules may be found on the Office of the Public Guardian website at**:** **http://www.publicguardian.gov.uk/about/court-of-protection.htm**

4.21 Other Aspects of the Mental Capacity Act (2005)[1]

4.21.1 Research

The Mental Capacity Act (MCA) (2005)[1] sets out a clear legal framework in relation to research involving people who may lack capacity. The proposed research participation must either produce a benefit to the person who lacks capacity, or the aim of the research must be to provide knowledge about the cause of, or treatment or care of people with the same impairing condition – or a similar condition (refer MCA Code of Practice-chapter 11)[2].

4.22 The Relationship between the Mental Capacity Act and the Mental Health Act.

The law and guidance states that the Mental Capacity Act should be an integral part of good practice in mental health care. However understanding when to apply the Mental Capacity Act rather than the Mental Health Act (MHA) takes some consideration (refer to MCA Code of Practice chapter 13[2] and MHA Code of Practice[4]). The amendments to the Mental Health Act (2007) introduced several elements of the Mental Capacity Act including the guiding principles; legal standard of capacity; changes to treatment with Electric Convulsive Therapy; treatments under Supervised Community Treatment Orders.

4.22.1 Within Inpatient settings:

The judgement in GJ v The Foundation Trust (2009) EWHC 2972[5] clearly outlined that where a person was admitted to a mental health inpatient unit for the treatment of mental disorder that the Mental Health Act must be applied. Staff must therefore use the Mental Health Act for the detention and treatment of people who lack the capacity to consent to their admission or on-going stay. Until this case law is overruled, it is very unlikely (although not impossible) for the Deprivation of Liberty Safeguards to be applied in mental health inpatient settings.

4.22.2 Within all other mental health settings (including community)

There is a need to be fluent with the Mental Capacity Act as this has much more relevance outside of the 'detention' situation. Quite often mental health practitioners will be working with both sets of law. The assessment of capacity within the Mental Capacity Act will guide the practitioners into the relevant legal framework depending on the decision to be made.

Mental health services for people aged 16 and 17 should refer to the section below.

4.23 Mental Capacity and young people

Many aspects of the Mental Capacity Act apply to people aged 16 and over who may lack capacity to make a specific decision (for more information see chapter 12 MCA Code of Practice)[2]. However the legislative framework for those cared for under The Children's Act (1989)[6] will continue to apply until they are discharged from such care proceedings.

There are two elements of the act than can be applied to young people under the age of 16

- Decisions about property or finance made by the Court of Protection
- Offences of ill treatment and wilful neglect

For young people aged 16 and 17 the capacity assessment must be used to determine whether the healthcare decision should be subject to the processes and provisions outlined within the Act. Depending upon the decision staff may then use the Children Act 1989 or the Mental Capacity Act to proceed with making a decision for the young person lacking capacity.

Where staff can demonstrate that they have acted in accordance with the Mental Capacity Act their actions will be protected from liability whether or not a person with parental responsibility consents. A young person's views on whether their parents should be consulted during the best interests process should be considered.

Where staff choose to proceed with consent from someone with parental responsibility, they must inform the parent that they are required to Act in the young person's best interests as outlined within the Act.

For those services working with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families in becoming familiar with the powers and provisions within the Act is an essential part of transition work. Families may choose to approach the Court to become Court Appointed Deputy for welfare decisions or property and finance decisions. Information should be provided to assist with such applications.

4.24 Implementation

The implementation of this policy is the responsibility of any member of staff working within the Trust who is involved in the decision making process of patients and their families. It is the responsibility of Divisional Managers and Clinical Directors to ensure that all their staff are familiar with the content of this policy and therefore applying it in their area of practice as appropriate**.**

This policy has been developed by The Trust Mental Capacity Leads who will continue to review the document in light of any changes or modifications to the existing legislation.

4.25 Further Support

If you require any practical advice and support or have any issues regarding the implementation and practice of the MCA 2005 please contact:

Kelly Short Safeguarding Adults Lead RLI ext 42425
Ranu Rowan Head of Legal Services WGH ext 46652

5. ATTACHMENTS	
Number	**Title**
1	Equality and Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/034	Deprivation of Liberty Safeguards http://uhmb/cs/tpdl/Documents/CORP-POL-034.docx
Corp/Pol/044	Restraint http://uhmb/cs/tpdl/Documents/CORP-POL-044.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

No.	References
1	Great Britain (2005) Mental Capacity Act 2005. [Online] Available from: http://www.legislation.gov.uk/ukpga/2005/9/contents (accessed 15.7.15)
2	DoH (2007) Mental Capacity Act: Code of Practice 2007. [Online] Available from: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice (accessed 15.7.15)
3	Great Britain (2007) Mental Health Act 2007. [Online] Available from: http://www.legislation.gov.uk/ukpga/2007/12/contents (accessed 15.7.15)
4	DoH (2015) Mental Health Act 1983: Code of Practice 2015. [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF (accessed 15.7.15)
5	GJ v The Foundation Trust (2009) EWHC 2972 Available from: http://www.mentalhealthlaw.co.uk/GJ_v_The_Foundation_Trust_(2009)_EWHC_2972_(Fam) (accessed 15.7.15)
6	Great Britain (1989) Children Act 1989. [Online] Available from: http://www.legislation.gov.uk/ukpga/1989/41/contents (accessed 15.7.15)
Bibliography	
	Great Britain (1998). *Human Rights Act 1998.* [Online] Available from: http://www.legislation.gov.uk/ukpga/1998/42/contents (accessed 15.7.15)
	European Convention on Human Rights Article 5 (i). Available from: http://www.echr.coe.int/Documents/Convention_ENG.pdf (accessed 15.7.15)
	The contact details for the local Independent Mental Capacity Advocacy (IMCA) service are available at: admin@advocacyfocus.org.uk

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
ADRT	Advance Decisions Refuse Treatment
DOLS	Deprivation of Liberty Safeguards
IMCA	Independence Mental Capacity Advocate
MCA	Mental Capacity Act
MHA	Mental Health Act
NHS	National Health Service

9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted

10. DISTRIBUTION PLAN	
Dissemination lead:	Kelly Short
Previous document already being used?	Yes / No (Please delete as appropriate)
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING

Is training required to be given due to the introduction of this procedural document? *Yes / No Please delete as appropriate

Action by	Action required	Implementation Date
Kelly Short	Training regarding MCA currently already being implemented within the Trust	19/12/2014

12. AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
1.1	19/04/2017	Section 5	List of attachments corrected	01/07/2018
1.2	04/10/2017	Page 4	BSF page added	01/07/2018
1.3	01/08/2018	Review Date	Review date extended. Form no. 107/2018	01/10/2018
1.4	23/11/2018	Review date	Review date extended. Form no. 159/2018	01/01/2019
1.5	19/02/2019	Page 1	Review Date extended – form 035/2019	01/05/2019

Appendix 1: EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Yes	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4a	**If so can the impact be avoided?**	NA	
4b	**What alternative are there to achieving the policy/guidance without the impact?**	NA	
4c	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the HR Equality & Diversity Specialist, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the HR Equality & Diversity Specialist, Extension 6242.