journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Contents

1 Introduction

This document provides direction and guidance to all staff involved in the assessment, care, treatment, or support of people over 16 years of age who may lack the capacity to make some or all decisions for themselves. It is based on the Mental Capacity Act 2005 (MCA).

The Trust's Journey to Change aims to provide a great experience for all of our patients by supporting them to achieve their goals and giving choice and control. These aims are also central to the MCA and following this policy will the Trust work within a legal framework and help achieve the goals within Our Journey to Change.

2 Why we need this policy

This document will help the Trust to meet its obligations to

- Guide practitioners in providing care to patients who lack the capacity to make specific decisions for themselves

2.1 Purpose

The Mental Capacity Act 2005 (MCA) serves to:

- Enshrine in statute best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf.
- Make clear who can take decisions, in which situations and how they should go about this.
- Provide for Lasting Powers of Attorney (LPA) to enable people to plan ahead for a time when they may lose capacity.
- The MCA also established a new Court of Protection to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision.

2.2 Objectives

This policy aims to

- Ensure that the MCA is used lawfully

3 Scope

3.1 Who this policy applies to

This policy applies to all Trust staff and should be considered in the care and treatment of patients. The MCA and the MCA Code of Practice have undergone extensive public consultation and promotes a respectful and compassionate approach to care, which aligns to the Trust values.

3.2 Statutory Principles

Tees, Esk and Wear Valleys NHS Foundation Trust is committed to abide by the five statutory principles which underpin the MCA and will ensure that the key principles are taken into account when applying decisions and actions under the MCA.

Chapter 2 Mental Capacity Act Code of Practice (MCA CoP) expands on the application of the statutory principles.

The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. 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 his best interests.
5. 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.

3.3 Code of Practice

The MCA does not impose a legal duty on anyone to 'comply' with the Code of Practice – it should be viewed as guidance rather than instruction. Where someone has not followed relevant guidance contained in the MCA CoP they will be expected to give good reasons why they have departed from it.

Certain categories of people are legally required to 'have regard to' relevant guidance in the MCA CoP. That means they must be aware of the MCA CoP when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and they should be able to explain how they have had regard to the MCA CoP when acting or making decisions.

The categories of people that are required to have regard to the MCA CoP include anyone who is:

- An attorney under a Lasting Power of Attorney (LPA);

- A deputy appointed by the Court of Protection;
- Acting as an Independent Mental Capacity Advocate (IMCA);
- Acting in a professional capacity for, or in relation to, a person who lacks capacity;
- Being paid for acts for or in relation to a person who lacks capacity.

The last two categories cover a wide range of people. People acting in a professional capacity may include:

- A variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc.);
- Social care staff (social workers, care managers, etc.);
- Others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as ambulance crew, housing workers or police officers.

People who are being paid for acts for or in relation to a person who lacks capacity may include:

- Care assistants in a care home;
- Care workers providing domiciliary care services, and
- Others who have been contracted to provide a service to people who lack capacity to consent to that service.

The MCA applies more generally to **everyone** who looks after, or cares for, someone who lacks capacity to make particular decisions for themselves. This includes family carers or other carers. Although these carers are not legally required to have regard to the MCA CoP, the guidance given will help them to understand the MCA and apply it. They should follow the guidance in the MCA CoP as far as they are aware of it.

3.4 Mental Capacity

Having mental capacity means that a person is able to make their own decisions. The first statutory principle of the MCA applies equally to people with mental disorder – 'a person must be assumed to have capacity unless it is established that they lack capacity.

3.4.1 What the MCA says

The MCA is designed to cover situations where someone is unable to make a decision because of an impairment of, or disturbance in, the functioning of their mind or brain. The MCA says that a person is unable to make a particular decision if, due to an impairment of, or a disturbance in the functioning of, their mind or brain they cannot:

- Understand information about the decision to be made (the relevant information);
- Retain the information in their mind;
- Use or weigh that information as part of the decision making process;
- Communicate their decision

Chapter 4 Mental Capacity Act Code of Practice (MCA CoP) expands on the definition of capacity.

3.4.2 How we use the MCA

To assess capacity, we first must carry out the 'functional test'. Only if the answer to any of the questions is 'no' in the functional test, do we proceed to the second stage of the test which is the 'diagnostic test'.

It is likely that a person with mental disorder will meet the requirements of the second stage of the capacity test, i.e., have an impairment of, or disturbance in, the functioning of the mind or brain. However, it must not be assumed that the person therefore lacks the capacity to make decisions.

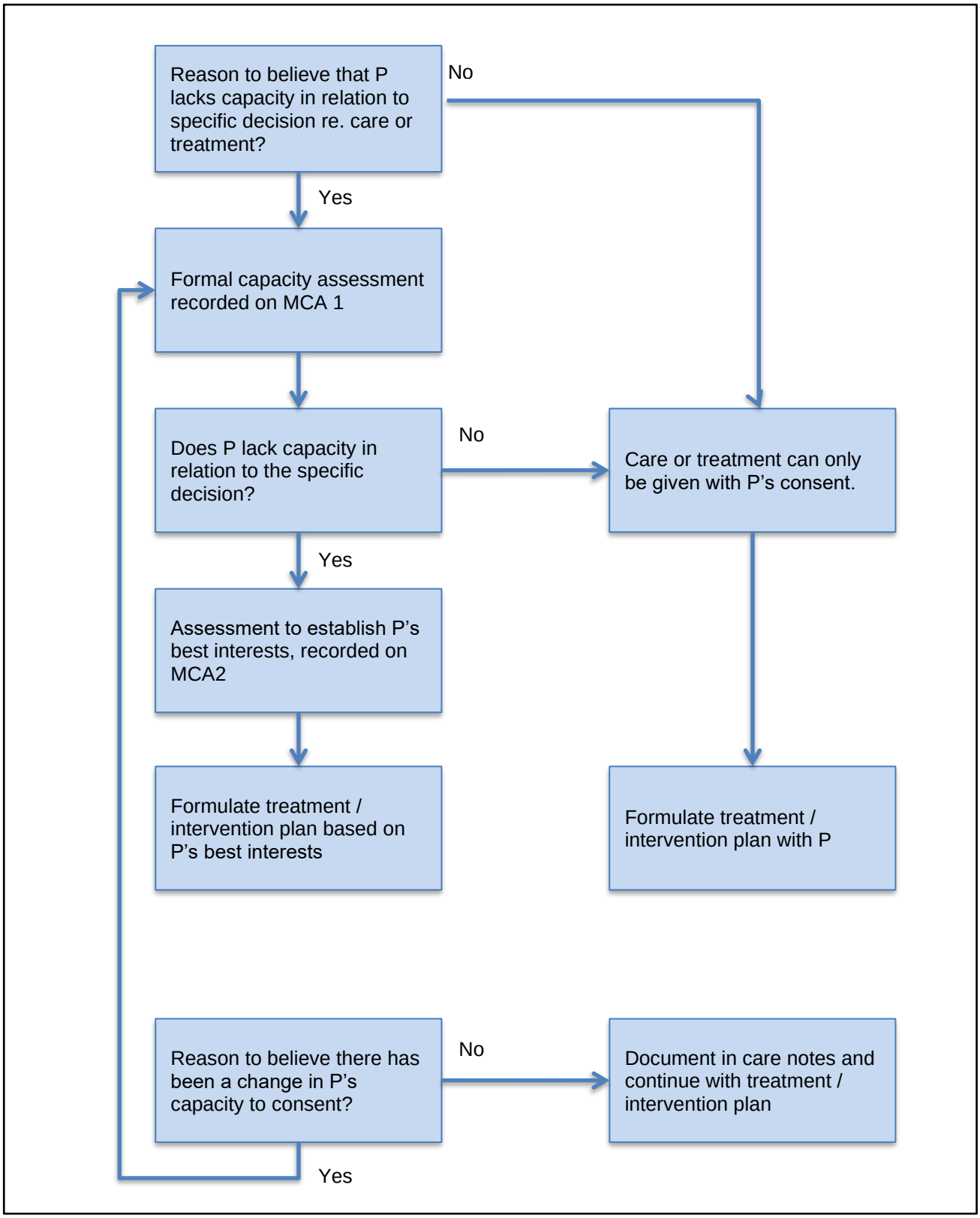
Some mental disorders have the potential to affect a person's ability to understand, retain, process or communicate information. Health professionals should be mindful of the possibility that mental disorder may have compromised a person's capacity to make specific decisions.

3.5 Best Interests

The term 'best interests' is not actually defined in the MCA. This is because so many different types of decisions and actions are covered by the MCA, and so many different people and circumstances are affected by it.

The MCA sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist is only the starting point: in many cases, extra factors will need to be considered.

3.6 Overview of MCA Process



3.7 Assuming Capacity

Principle 1 of the MCA means that when assessing capacity, we must always begin by assuming that a person is capable of making the particular decision unless it can be established otherwise. Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make the decision themselves.

Decisions will **not** be made about a person's capacity to make a decision based on the person's age, appearance or unjustified assumptions about capacity based on the person's condition or behaviour.

Chapter 3 MCA CoP expands on this information

Where a patient's capable consent is being relied upon to provide authority for an act of care or treatment or other decision there must be a statement acknowledging this in the patient's record.

3.7.1 Supported Decision Making

The second principle of the MCA is that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. This underpins the approach of supported decision making where staff should do all they can to support the person to make their own decision. Staff should try to evidence what practicable steps they have taken to enable the patient to make a decision. This may include the information that has been given, who is involved that can help and the way in which this has been done. Staff should document the steps they have taken, and any tools or approaches used in this process.

3.8 Assessing Capacity

Having mental capacity means a person is able to make their own decisions. A person can lack capacity for the purposes of the MCA even if the loss is partial or temporary or if capacity fluctuates over time. A person may lack capacity to make one decision but not others.

If there is a belief that a person lacks the capacity to make a specific decision, then it must be demonstrated that on the *balance of probabilities* that the person lacks the necessary capacity to make the decision at the time it needs to be made. Where clinicians feel a patient is making multiple unwise decisions, this does not mean a patient lacks capacity, but *may* be an indication that capacity should be assessed.

Where there is doubt about a person's capacity to make a specific decision, consideration should be given to:

- Does the decision need to be made immediately?
- If not, is it possible to delay the decision until the person has capacity to make the decision themselves?
- Has everything been done to help and support the person making the decision?

In supporting people to make decisions consideration should be given to the following questions:

- Has the person had all the relevant information needed to make the decision in question?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Are there particular times of the day when the person's understanding is better or particular locations where they feel more at ease?
- Can the decision be put off until the circumstances are right for the person concerned?
- Can anyone else help or support the person to make choices or express a view, such as an independent advocate or someone to assist communication.

To determine whether an individual has the capacity to make a particular decision, a two-stage process will be used as described below.

The 'functional test' - Can the person:

- Understand information about the decision to be made (relevant information);
- Retain the information in their mind long enough to be able to make the decision;
- Use or weigh that information as part of the decision-making process;
- Communicate their decision – this could be talking, using sign language or even simple muscle movements such as blinking an eye.

If the answer to all of the above is yes, then the person has capacity to make the decision in question.

If the answer to any of the above is no, then move to the diagnostic test.

The 'diagnostic test'

Does the person have an impairment of or a disturbance in the functioning of their mind or brain? There will be an assessment as to whether there is an impairment or disturbance in the functioning of the person's mind or brain, examples of which may include, but are not limited to:

- Conditions associated with some forms of mental illness;
- Dementia;
- Significant learning disabilities;
- The long-term effects of brain damage;
- Physical or mental conditions that cause confusion, drowsiness or loss of consciousness;
- Delirium;
- Concussion following a head injury, and
- The symptoms of alcohol or drug use.

If the person does have an impairment or disturbance in functioning of their mind or brain, is that impairment or disturbance the reason why they are unable to understand, and/or retain and/or use or weigh and/or communicate, i.e., the causal link?

If there is no impairment of, or disturbance in the functioning of their mind or brain, the person cannot lack capacity for the purposes of the MCA.

A person should not be deemed to be without capacity because they make what seem to be 'unwise' decisions.

Executive Functioning

There is a potential that executive functioning, or executive dysfunction, is treated as separate to the assessment of capacity, e.g., the person has capacity but lacks executive function therefore... This is not how executive functioning difficulties or deficits should be considered in terms of assessing capacity. Executive dysfunction can impact on a person's ability to understand information or to use and weigh information and therefore may be a reason why the person lacks capacity, i.e., they are unable to use or weigh information due to executive dysfunction. This may manifest as:

- Impulsivity
- Lack of problem solving
- Lack of initiation
- Difficulty planning
- Able to say but not to do
- Right answers, not able to put into practice

When assessing capacity for someone who may have difficulties with executive functioning it is important to try to understand their specific impairments e.g., do they have difficulty in planning, executing, impulse control, and to triangulate that with observations and the accounts of others.

3.9 Who should assess capacity?

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made.

In general terms, the person who is proposing to take a particular action in connection with the care or treatment of an individual will be responsible for assessing the individual's capacity to consent to that particular action.

This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

3.10 Recording Assessments of Capacity

Although the starting point must always be a presumption of capacity, health professionals should always make an assessment of an individual's capacity to make particular treatment or care related decisions and record the findings in the relevant professional records.

An assessment of the individual's capacity to consent or agree to the provision of services will be part of the care planning processes for health and social care needs and should be recorded in the relevant documentation. This includes:

- Person Centred Planning for people with learning disabilities;
- The Care Programme Approach for people with mental illness; and
- The Single Assessment Process for older adults in England.

Within TEWV, any professional proposing treatment or another act should carry out an assessment of the individual's capacity to consent (with a multi-disciplinary team, if appropriate), clearly documenting the steps taken and record in it the electronic patient record.

Where there are concerns around whether the individual has the capacity to consent or refuse to consent to the treatment or act, or to make a specific decision, a formal assessment of mental capacity must be carried out and recorded on Form MCA1. Form MCA 1 is available in the electronic patient records.

If the outcome of the capacity assessment is that the patient has capacity to make the decision, the act of care or treatment will be authorised by the patient's consent.

Where a patient's capable consent is being relied upon to provide authority for an act of care or treatment there must be a statement acknowledging this in the patient's record.

3.11 Best Interests

If a person has been assessed as lacking capacity, then any act done for, or decision made on behalf of the person lacking capacity must be done or made in that person's best interests.

Under the MCA, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make a particular decision for themselves. The person making the

decision is referred to as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

Careful consideration should be given to who the decision-maker is:

- Where a deputy has been appointed by the Court of Protection to make welfare decisions such as the one in question then the deputy will be the decision maker.
- If an attorney has been appointed under a Lasting Power of Attorney to make such decisions then the attorney will be the decision maker
- In the absence of a deputy or attorney the decision maker will be the person responsible for the act of care or treatment in question.

Because every case – and every decision – is different, the law cannot set out all the factors that will need to be taken into account in working out someone's best interests. Section 4 of the MCA sets out common factors that **must always** be considered when trying to work out someone's best interests. These factors are summarised in the checklist here:

Chapter 5 of the MCA CoP gives more detail on best interests.

- Working out what is in someone's best interests cannot be based simply on someone's age appearance, condition or behaviour. Paragraphs 5.16-5.17 MCA CoP.
- All relevant circumstances should be considered when working out someone's best interests. Paragraphs 5.18-5.20 MCA CoP.
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision. Paragraphs 5.21-5.24 MCA CoP.
- If there is a chance that a person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent. Paragraphs 5.29-5.36 MCA CoP.
- Special considerations apply to decisions about life-sustaining treatment. Paragraphs 5.29-5.36 MCA CoP.
- The person's past and present wishes and feelings, beliefs and values should be taken into account. Paragraphs 5.37-5.48 MCA CoP.

Best interests assessments must be documented appropriately using Form MCA2. Form MCA2 is available within the electronic patient records.

3.12 Exceptions to the best interest's principle

There are two circumstances where the best interests principle does not apply:

Firstly, where someone has previously made a valid and applicable advance decision to refuse medical treatment, their decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests.

Chapter 9 MCA CoP gives further guidance on advance decisions

The second concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent.

Chapter 11 MCA CoP gives further guidance on research.

3.13 Acts in Connection with Care or Treatment

This is considered in depth in Chapter 6 of the MCA CoP

Section 5 of the MCA allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent.

Section 5(1) provides possible protection for actions carried out *in connection with care or treatment.* The action may be carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in that person's best interests. The MCA does not define 'care' or 'treatment.' Section 64(1) makes it clear that treatment includes diagnostic or other procedures.

Actions that might be covered by section 5 include

In relation to personal care:

- Helping with washing, dressing or personal hygiene
- Helping with eating and drinking
- Helping with communication
- Helping with mobility (moving around)
- Helping someone take part in education, social or leisure activities
- Going into a person's home to drop off shopping or to see if they are alright
- Doing the shopping or buying necessary goods with the person's money
- Arranging household services (for example, arranging repairs or maintenance for gas and electricity supplies)

- Providing services that help around the home (such as homecare or meals on wheels)
- Undertaking actions related to community care services (for example, day care, residential accommodation or nursing care)
- Helping someone to move home (including moving property and clearing the former home)

In relation to healthcare and treatment

- Carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
- Providing professional medical, dental and similar treatment
- Giving medication
- Taking someone to hospital for assessment or treatment
- Providing nursing care (whether in hospital or in the community)
- Carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example physiotherapy or chiropody)
- Providing care in an emergency

Some acts in connection with care or treatment may cause major life changes with significant consequences for the person concerned. Those requiring particularly careful consideration include a change of residence, perhaps into a care home or nursing home, or major decisions about healthcare and medical treatment.

3.14 Limitations to Protection from Liability

Professionals will be protected from liability under Section 5 if they can demonstrate that they have taken appropriate steps to assess capacity, reasonably believe that the person lacks capacity and can demonstrate that they have carried out a best interest assessment and reasonably believe that the act is in best interests.

Section 5 does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary

Acts may not be protected from liability where there is inappropriate use of restraint

Acts may not be protected from liability where a person who lacks capacity is deprived of their liberty without authorisation

3.15 Restraint

The MCA defines restraint as the use or threat of force to make someone do something they are resisting or to restrict a person's freedom of movement whether they are resisting or not.

Staff will only attract protection from liability when carrying out an action intended to restrain a person who lacks capacity if the following conditions are met:

- The person taking action must reasonably believe that restraint is **necessary** to prevent **harm** to the person who lacks capacity; **and**
- The amount or type of restraint used and the amount of time it lasts must be a **proportionate response** to the likelihood and seriousness of harm.

3.16 Deprivation of Liberty

The MCA on its own cannot authorise a deprivation of liberty.

A deprivation of liberty that is not authorised is unlawful

There is a deprivation of liberty where a person:

- Lacks capacity to consent to decide whether they should be accommodated to be given care or treatment; and
- Is under continuous supervision and control; and
- Is not free to leave

A deprivation of liberty can be authorised by:

- A deprivation of liberty safeguards (DoLS) authorisation;
- The Mental Health Act 1983 (MHA), where applicable and appropriate;
- The Court of Protection.

For further information see:

- **Tees, Esk and Wear Valleys NHS Foundation Trust Deprivation of Liberty policy**
- **Tees, Esk and Wear Valleys NHS Foundation Trust Deprivation of Liberty Safeguards Procedure**
- **MCA Deprivation of Liberty Safeguards Code of Practice.**

Also see Chapter 13 MHA Code of Practice

3.17 Capacity to consent to admission/remaining in hospital

For the care regime to amount to a deprivation of liberty, the person must be unable to give their consent to the accommodation arrangements made for their care or treatment.

Where a person has capacity and freely consents to the accommodation arrangements made for their care and treatment regime there can be no deprivation of liberty under the Mental Capacity Act 2005 (MCA).

In order to give valid consent to admission to, or remaining in, a mental health unit the person must have the capacity to consent to the actual care and treatment regime that will be in place for them.

Valid consent requires that the person is given sufficient information relevant to the decision and the information they are consenting in this instance to will include:

- That they are/will be in hospital to receive care and treatment for a mental disorder;
- The core elements of that care and treatment and measures which may be put in place to supervise the patient for example:
  - Prescription and administration of medication for the treatment of mental disorder;
  - Observation levels;
  - Time away from the ward may be escorted only;
  - Visits may be supervised;
- What steps may be taken in respect of searching of the patient and their property;
- What would happen if the patient tried to leave hospital

For consent to be valid it must also be freely given and the person must not be under any duress or inappropriate pressure. Agreement given under duress or any other pressure is not consent.

3.18 Goods and Services

Carers may have to spend money on behalf of someone who lacks capacity to purchase necessary goods and services. For example they may need to pay for a milk delivery or for a chiropodist to provide a service at the person's home.

In some cases they may have to pay for more costly arrangements such as house repairs or organising a holiday. Carers are likely to be protected from liability if their actions are properly taken under section 5 and the goods and services are **necessary and in the best interests** of the person who lacks capacity.

'Necessary' means something that is suitable to the person's condition in life (their place in society, rather than any mental or physical condition) and their actual requirements when the goods or services are provided. The aim is to make sure that people can enjoy a similar standard of living and way of life to those they had before lacking capacity.

Carers should keep bills, receipts and other proof of payment when paying for goods and services. They will need these documents when asking to get money back. Keeping appropriate financial

records and documentation is a requirement of the national minimum standards for care homes or domiciliary care agencies.

The MCA does not give a carer or care worker access to a person's income or assets. Nor does it allow them to sell the person's property.

Anyone wanting access to money in a person's bank or building society will need formal legal authority. They will also need legal authority to sell a person's property. Such authority could be given:

- in a Lasting Power of Attorney;
- by the Court of Protection in the form of a single decision;
- by the Court of Protection by appointing a deputy to make financial decisions for the person who lacks capacity.

See MCA CoP Paragraphs 6.56-6.66 for further information

3.19 Excluded Decisions

The Act covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. There are certain decisions which can never be made on behalf of a person who lacks capacity to make them, this is because they are so personal to the individual or governed by other legislation.

Nothing in the Act permits a decision to be made on someone else's behalf on 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
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property
- Giving consent under the Human fertilisation and Embryology Act 1990
- Voting

Where a person who lacks capacity to consent is currently detained and being treated under Part IV of the MHA, nothing in the MCA authorises anyone to:

- **Give the person treatment for mental disorder**
- **Consent to the person being given treatment for mental disorder**

See MCA CoP Paragraphs 1.8-1.11 for further information

3.20 Information sharing

Much of the information required to assist and inform the decision making process under the Act is sensitive or confidential. It is regulated by:

- The Data Protection Act 2018
- The common law duty of confidentiality
- Professional codes of conduct on confidentiality
- Information sharing protocols, and
- The Human Rights Act 1998 and European Convention on Human Rights

The Data Protection Act 2018 gives everyone the right to see personal information that an organisation holds about them. They may also authorise someone else to access their information on their behalf. The person holding the information has a legal duty to release it. So, where possible, it is important to try to get a person's consent before requesting to see information about them.

An attorney acting under a valid LPA or EPA (and sometimes a deputy) can ask to see information concerning the person they are representing, as long as the information applies to decisions the attorney has the legal right to make. Attorneys and deputies should only ask for information that will help them make a decision they need to make on behalf of the person who lacks capacity. The person who releases information must make sure that an attorney or deputy has official authority (they may ask for proof of identity and appointment).

The information may be held in one or more of the following forms:

- Electronic Patient Records
- MHA Documentation
- Paper files

Access should be facilitated by a professionally qualified member of staff with knowledge of the patient. In the case of records held on the electronic patient records, the access can be facilitated either by showing the relevant parts of the record or selectively printing the relevant sections.

The deputy or attorney may find that some information is held back (for example, when this contains references to people other than the person who lacks capacity). This might be to protect another person's privacy, if that person is mentioned in the records. It is unlikely that information

relating to another person would help an attorney make a decision on behalf of the person who lacks capacity. The information holder might also be obliged to keep information about the other person confidential. There might be another reason why the person does not want information about them to be released. Under these circumstances, the attorney does not have the right to see that information.

An information holder should not release information if doing so would cause serious physical or mental harm to anyone – including the person the information is about. This applies to information on health, social care and education records.

Chapter 16 MCA CoP gives further information around the rules governing access to information

3.21 Independent Mental Capacity Advocates (IMCAs)

3.21.1 Purpose of the IMCA service

The purpose of the IMCA service is to provide independent safeguards and to help people who lack capacity to make certain important decisions about serious medical treatment and changes of accommodation, and who have no family or friends (other than paid carers) that it would be appropriate to consult about those decisions. Whether a person is appropriate to consult relates, for example, to whether they are able to be contacted, whether they are willing and able to be consulted or to represent the person.

A person should not be deemed inappropriate to consult in circumstances where, for example, they disagree with the decision maker's proposed action.

3.21.2 Serious medical treatment

It is impossible to set out all types of procedures that may amount to "serious medical treatment," examples of medical treatments that might be considered serious include:

- Chemotherapy and surgery for cancer
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (such as open-heart surgery or brain / neurosurgery)
- Major amputations (e.g. loss of arm or leg)
- Treatments which will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition or hydration
- Termination of pregnancy

These are illustrative examples only, and whether these or other procedures are considered serious medical treatment in any given case, will depend on the circumstances and the consequences for the patient. It could be that the provision of antibiotics could be considered serious medical treatment where there are serious consequences if treatment is not provided.

3.21.3 When an IMCA MUST be Instructed

Where a person lacks capacity to make a particular decision and is "un-befriended" as described above, decision makers in local authorities and NHS Trusts have a duty to instruct an IMCA where:

- The decision is about serious medical treatment provided by or proposed by the NHS *(but excludes treatment regulated under Part IV of the Mental Health Act 1983);*
- It is proposed by the NHS or Local Authority that the person be moved to long-term care of more than 28 days in a hospital or 8 weeks in a care home *(where that accommodation or move is not a requirement of the Mental Health Act 1983);*
- A long-term move (8 weeks or more) to different accommodation is being proposed by the NHS or Local Authority, for example a move to a different hospital or care home *(where that accommodation or move is not a requirement of the Mental Health Act 1983).*

The only situation in which the duty to instruct an IMCA need not be followed is when an urgent decision is needed (e.g. to save the person's life)

Any such decision must be recorded with the reason for the non-referral. Responsible bodies will however still need to instruct an IMCA for any serious treatment that follows the emergency treatment.

MCA CoP 10.46

3.21.4 When an IMCA MAY be Instructed

Local Authorities and the NHS are authorised to instruct an IMCA for two further types of decisions if they are satisfied that an IMCA would be of particular benefit. These are:

- Care reviews about accommodation or changes to accommodation, and
- Adult protection cases where the person without capacity is or has been abused, or is or has been an abuser but only where protective measures have been, or are proposed to be taken (this applies even if the person who lacks capacity has family and/or friends).

3.21.5 Role of the IMCA

An IMCA must decide how best to represent and support the person who lacks capacity that they are helping. They:

- Must confirm that the person instructing them has the authority to do so
- Should interview or meet in private the person who lacks capacity, if possible
- Must act in accordance with the principles of the Act (as set out in section of the Act and chapter 2 of the Code) and take account of relevant guidance in the Code
- May examine (and take copies of) any relevant records that section 35(6) of the Act gives them access to[1]
- Should get the views of professionals and paid workers providing care or treatment for the person who lacks capacity
- Should get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity
- Should get hold of any other information they think will be necessary
- Must find out what support a person who lacks capacity has had to help them make the specific decision
- Must try to find out what the person's wishes and feelings, beliefs and values would be likely to be if the person had capacity
- Should find out what alternative options there are
- Should consider whether getting another medical opinion would help the person who lacks capacity, and
- Must write a report on their findings for the local authority or NHS body

3.21.6 IMCA Referrals

When a decision maker makes a referral to the IMCA Service, the referral should be to the IMCA Service in the Local Authority area where the incapacitated person currently is.

Who to refer to is not based on ordinary residence but instead on the location of the person at the time the decision needs to be made/ treatment provided.

[1] This includes any health record, any record of, or held by, a Local Authority, any record held by a person registered under Part 2 of the Care Standards Act. There is no specific process for IMCAs accessing healthcare records; they are NOT required to go through the Access to Health Records Procedure though they should only be given access to the information relevant to the decision that is required to be made. Access should be facilitated by a professionally qualified member of staff with knowledge of the patient. In the case of records held on the electronic patient records, the access can be facilitated either by showing the relevant parts of the record or selectively printing the relevant sections

Local Authorities have commissioned the IMCA Services for their local authority areas, the IMCA page on InTouch has up to date contact information

3.22 Advance Decisions

An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision.

Chapter 9 MCA Code of Practice gives further information about Advance Decisions

Tees, Esk and Wear Valleys NHS Foundation Trust staff should follow the Advance Decision and Request Policy CLIN/0011/v1.

Advance Decisions are also covered in Tees, Esk and Wear Valleys NHS Foundation Trust Consent to Examination and Treatment Policy

3.23 Court of Protection

3.23.1 The Court

Section 45 of the Act established a specialist court, the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves.

As well as property and affairs, the new court also deals with serious decisions affecting healthcare and personal welfare matters.

The Court of Protection is a superior court of record and is able to establish precedent (it can set examples for future cases) and build up expertise in all issues related to lack of capacity. It has the same powers, rights, privileges and authority as the High Court.

When reaching any decision, the court must apply all the statutory principles set out in section 1 of the Act. In particular, it must make a decision in the best interests of the person who lacks capacity to make the specific decision.

3.23.2 Powers of the Court of Protection

The Court of Protection may:

- Make declarations, decisions and orders on financial and welfare matters affecting people who lack, or are alleged to lack, capacity (the lack of capacity must relate to the particular issue being presented to the court)

- Appoint deputies to make decisions for people who lack capacity to make those decisions
- Remove deputies or attorneys who act inappropriately.
- The Court can also hear cases about LPAs and EPAs. The court's powers concerning EPAs are set out in Schedule 4 of the Act.

3.23.3 Decisions that must come before the Court of Protection

Cases involving any of the following decisions should be brought before a court:

- Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- Cases involving organ or bone marrow donation by a person who lacks capacity to consent
- Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- All other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.

If a decision requires to be made that may need to involve the Court of Protection, in the first instance advice and guidance should be sought from the Mental Health Legislation Lead or the Associate Director of Nursing and Governance.

Chapter 8 MCA CoP gives further information about the Court of Protection and Court Appointed Deputies

3.23.4 Court Appointed Deputies

3.23.4.1 Appointing a Deputy

Sometimes it is not practical or appropriate for the court to make a single declaration or decision. In such cases, if the court thinks that somebody needs to make future or ongoing decisions for someone whose condition makes it likely they will lack capacity to make some further decisions in the future, it can appoint a deputy to act for and make decisions for that person:

- In the majority of cases, the deputy is likely to be a family member or someone who knows the person well.
- Deputies must be at least 18 years of age.

- Deputies with responsibility for property and affairs can be either an individual or a trust corporation (often parts of banks or other financial institutions).
- No-one can be appointed as a deputy without their consent.
- Paid care workers (for example, care home managers) should not agree to act as a deputy because of the possible conflict of interest – unless there are exceptional circumstances (for example, if the care worker is the only close relative of the person who lacks capacity).
- The court can appoint someone who is an office-holder or in a specified position (for example, the Director of Adult Services of the relevant local authority). In this situation, the court will need to be satisfied that there is no conflict of interest before making such an appointment.

3.23.4.2 Responsibilities of Deputies

Once a deputy has been appointed by the court, the order of appointment will set out their specific powers and the scope of their authority. On taking up the appointment, the deputy will assume a number of duties and responsibilities and will be required to act in accordance with certain standards.

Failure to comply with the duties set out below could result in the Court of Protection revoking the order appointing the deputy and, in some circumstances, the deputy could be personally liable to claims for negligence or criminal charges of fraud.

Deputies should always inform any third party they are dealing with that the court has appointed them as deputy. The court will give the deputy official documents to prove their appointment and the extent of their authority.

A deputy must act whenever a decision or action is needed and it falls within their duties as set out in the court order appointing them. A deputy who fails to act at all in such situations could be in breach of duty.

3.23.4.3 Duties of Deputies

Deputies must:

- Follow the Act's statutory principles (see chapter 2)
- Make decisions or act in the best interests of the person who lacks capacity
- Have regard to the guidance in this Code of Practice
- Only make decisions the Court has given them authority to make.

- Deputies must carry out their duties carefully and responsibly. They have a duty to:
  - Act with due care and skill (duty of care)
  - Not take advantage of their situation (fiduciary duty)
  - Indemnify the person against liability to third parties caused by the deputy's negligence
  - Not delegate duties unless authorised to do so
  - Act in good faith
  - Respect the person's confidentiality, and
  - Comply with the directions of the Court of Protection.

- Property and affairs deputies also have a duty to:
  - Keep accounts, and
  - Keep the person's money and property separate from own finances.

3.23.4.4 Supervising Deputies

Deputies are accountable to the Court of Protection. The court can cancel a deputy's appointment at any time if it decides the appointment is no longer in the best interests of the person who lacks capacity.

The OPG is responsible for supervising and supporting deputies. But it must also protect people lacking capacity from possible abuse or exploitation. Anybody who suspects that a deputy is abusing their position should contact the OPG immediately. The OPG may instruct a Court of Protection Visitor to visit a deputy to investigate any matter of concern. It can also apply to the court to cancel a deputy's appointment.

The OPG will consider carefully any concerns or complaints against deputies. But if somebody suspects physical or sexual abuse or serious fraud, they should contact the police and/or social services immediately, as well as informing the OPG.

MCA CoP Paragraphs 8.31-8.71 expand on information about Court Appointed Deputies

The OPG can be contacted on 0845 230 3900 or at their website www.publicguardian.gov.uk

3.24 Lasting Power of Attorney

3.24.1 What is a Lasting Power of Attorney?

The Mental Capacity Act replaces the Enduring Power of Attorney (EPA) with the Lasting Power of Attorney (LPA).

A Power of Attorney is a legal document that allows one person (the donor) to give another person (the donee or attorney) authority to make decisions on their behalf which are as valid as if made by the person themselves.

LPAs can cover personal welfare (including healthcare and consent to medical treatment) and property and affairs (including financial matters) for people who lack capacity to make such decisions for themselves.

3.24.2 Personal Welfare LPAs

LPAs can be used to appoint attorneys to make decisions about personal welfare, which can include healthcare and medical treatment decisions. Personal welfare LPAs might include decisions about:

- Where the donor should live and who they should live with
- The donor's day-to-day care, including diet and dress
- Who the donor may have contact with
- Consenting to or refusing medical examination and treatment on the donor's behalf
- Arrangements needed for the donor to be given medical, dental or optical treatment
- Assessments for and provision of community care services
- Whether the donor should take part in social activities, leisure activities, education or training
- The donor's personal correspondence and papers
- Rights of access to personal information about the donor, or
- Complaints about the donor's care or treatment.

The standard form for personal welfare LPAs allows attorneys to make decisions about anything that relates to the donor's personal welfare. But donors can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare.

A general personal welfare LPA gives the attorney the right to make all of the decisions set out above although this is not a full list of the actions they can take or decisions they can make.

A personal welfare LPA can only be used at a time when the donor lacks capacity to make a specific welfare decision.

A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the LPA that they do not want the attorney to make these decisions.

Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

- **The donor has capacity to make the particular healthcare decision (section 11(7)(a))**
    - An attorney has no decision making power if the donor can make their own treatment decisions
- **The donor has made an advance decision to refuse the proposed treatment (section 11(7)(b))**
    - An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.
- **A decision relates to life-sustaining treatment (section 11(7)(c))**
    - An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this.
- **The donor is detained under the Mental Health Act (section 28)**
    - An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983.

3.24.3 Confirming the Existence and Validity of an LPA

If a service user has appointed an attorney under an LPA, it is essential that any member of staff wishing to make a decision or carry out an act can satisfy themselves that the attorney has the necessary authority to make decisions on behalf of the person lacking capacity, or that they must be consulted.

For an LPA to be valid and binding, it must be registered with the Office of the Public Guardian (OPG). Any staff member wanting to confirm that an LPA is valid, i.e. registered, not revoked and the attorney has not been removed, should contact the MHL Department in their locality who will contact the OPG on their behalf to confirm this. The OPG is only contactable in office hours, i.e. Monday – Friday, 9-5.

Chapter 7 MCA CoP gives further information about LPAs

3.25 Resolving Disputes

Disagreements about healthcare, social or other welfare services may be between:

- People who have assessed a person as lacking capacity to make a decision and the person they have assessed
- Family members or other people concerned with the care and welfare of a person who lacks capacity
- Family members and healthcare or social care staff involved in providing care or treatment
- Healthcare and social care staff who have different views about what is in the best interests of a person who lacks capacity.

Disagreements and disputes can be resolved either informally or if the informal route fails, formally.

Initially, disagreements and disputes can be resolved through the use of effective communication between all people involved.
If this is unsuccessful, then the Patient Advice and Liaison Service (PALS) can be utilised as an informal means of addressing healthcare issues.
Following this, if the issue remains unresolved, then a formal complaint can be made.

For disagreements about social care, the Local Authority complaints procedure should be utilised.

Chapter 15 MCA CoP gives further information on resolving disagreements and disputes about issues covered in the MCA

3.26 Interface with the Mental Health Act

See chapter 13 MHA Code of Practice

Professionals may need to think about using the MHA to detain and treat somebody who lacks capacity to consent to treatment (rather than use the MCA), if:

- It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty
- The person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
- The person may need to be restrained in a way that is not allowed under the MCA

- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

Before making an application under the MHA, decision-makers should consider whether they could achieve their aims safely and effectively by using the MCA instead.

Compulsory treatment under the MHA is not an option if:

- The patient's mental disorder does not justify detention in hospital, or
- The patient needs treatment only for a physical illness or disability.

The MCA applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

- If someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person's behalf
- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live, and
- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

Healthcare staff cannot give psychosurgery (i.e. neurosurgery for mental disorder) to a person who lacks the capacity to agree to it.
This applies whether or not the person is otherwise subject to the MHA.

3.27 Offences

The MCA introduced two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions (section 44 MCA). The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carers, healthcare 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.

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years – or both.

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
- Been reckless as to whether they were ill-treating the person or not.

It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

The meaning of 'wilful neglect' varies depending on the circumstances.

It usually means that a person has deliberately failed to carry out an act they knew they had a duty to do.

Allegations of offences may be made to the police or the Office of the Public Guardian. They can also be dealt with under adult protection procedures (via adult services in social services departments).

4 Definitions

Term	Definition
Mental Capacity Act (MCA)	Mental Capacity Act 2005 is the legislation that guides how to assess capacity and how to provide care and treatment to people who lack capacity.
Mental Health Act (MHA)	Mental Health Act is the legislation used in the detention and treatment of people with a mental disorder.
Best Interest (BI)	When someone is found to lack capacity and a decision has to be made for them, the decision must be in the best interest of the person.
Lasting Power of Attorney (LPA)	There is a financial LPA and a health and welfare LPA. A person with capacity can decide who they want their LPA to be. This must be registered with the office of the public guardian. Once registered the LPA can make decisions on behalf of someone if they lose capacity.
Court of Protection (CoP)	The Court of Protection is the court that oversees matters relating to patients who do not have capacity.
Independent Mental Capacity Advocate (IMCA)	IMCA are a type of advocate that support patients who do not have capacity. There are certain situations where an IMCA must be appointed.
Court appointed deputy	This is someone who is instructed by the Court of Protection to make decisions on behalf of someone who lacks capacity.

5 Related documents

- TEWV DoLS Policy / DoLS Procedure
- TEWV Advance Decisions Procedure

6 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

6.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff with a professional registration	MHL level 2 e-learning	3 hours	Every 2 years
All clinical staff without a professional registration	MHL level 1 e-learning	3 hours	Every 2 years

7 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Audit on electronic records to assess compliance with policy and quality of documentation in relation to MCA (6699 CEN21 MCA Audit)	MHL department	Results will be shared with the Mental Health Legislation committee and appropriate governance group.

8 References

Mental Capacity Act 2005
Mental Capacity Act Code of Practice

Mental Capacity Act 2005 Code of Practice, TSO, 2007
Mental Health Act 1983: Code of Practice, TSO, 2015
Mental Capacity Act 2005 Deprivation of Liberty Safeguards, TSO, 2008

9 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	20 December 2023
Next review date	30 September 2025
This document replaces	CLIN-0009-v5.2 Mental Capacity Act 2005 Policy
This document was approved by	Mental Health Legislation Committee
This document was approved	13 November 2023
This document was ratified by	Management Group
This document was ratified	20 December 2023
An equality analysis was completed on this policy on	December 2021
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
5	3 Dec 2015	Full review and reformatting for ease of reading	Withdrawn
5.1	3 Apr 2018	Document fully reviewed with no changes arising except Forms MCA1 and MCA2 updated (n.b. new documentation was discussed and agreed at the January 2018 MHLC)	Withdrawn
5.1	27 Mar 2019	Document Control – approval and review date amendments made	Withdrawn
5.1	2020	Review date portfolio extension six months	Withdrawn
5.1	01 Mar 2021	Review date extended to 03 December 2021	Withdrawn
5.2	17 Feb 2022	Three yearly review with minor changes:- • Policy template updated to include Our Journey to Change. • Additional guidance added to section 4.7 following recommendations from the Teeswide Safeguarding Adults Board. • Reference to Data Protection Act 2018 updated.	Withdrawn

		• Updated contact details.	
5.3	20 Dec 2023	Minor wording changes In sections 3.10, 3.11 and 3.20 “Paris” changed to “Electronic Patient Record” In section 3.24.3 “MHA Department” changed to “MHL Department” In section 3.4 - minor wording change “first” to “second” to reflect correct order of two stage capacity test. Section 3.4.1 and 3.4.2 headings added. Section 3.8 Changed order of two stage capacity process and added paragraph for executive functioning In section 3.25 - Updated to reflect current practice.	Ratified
5.3	Jul 2024	Review date extended from 20/07/2025 to 30/09/2025.	Published

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Mental Health Legislation
Title	Mental Capacity Act 2005
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	This document provides direction and guidance to all staff involved in the assessment, care, treatment or support of people over 16 years of age who may lack the capacity to make some or all decisions for themselves.
Start date of Equality Analysis Screening	March 2021
End date of Equality Analysis Screening	December 2021

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	This policy aims to benefit staff and patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO**

	• **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Yes - see references
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	This policy directly reflects and interprets statutory legislation and associated code of practice which undertook its own extensive engagement and consultation process.

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No

Describe any training needs for Trust staff	Training to be covered in mandatory MHL e-learning
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	NA	