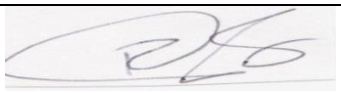
North East London NHS
NHS Foundation Trust

ASSESSMENT OF MENTAL CAPACITY POLICY

Lead executive director:	Trudie Rossouw, Acting Executive Medical Director
Lead executive director sign off prior to the approval process:	
Date of sign off by lead executive director:	30.03.2015
Name of originator / author and job title:	Susan Smyth – Interim Director of Nursing (Clinical Effectiveness) Linked to Barts Health Economy
Approved by:	Executive Management Team
Approval date:	02.04.2015
Implementation date:	02.04.2015
Review date:	April 2018
Date equality impact assessment carried out:	04.03.2015

North East London NHS
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Document Control Sheet

Policy title	Assessment of Mental Capacity (Policy and Procedure)			
Policy number	TW/CL0083/v001			
Assurance statement	The purpose of this policy is to embody the principles and practice of the Mental Capacity Act 2005 in the clinical practice of the Trust, specifically around the assessment of mental capacity and the making of best interest decisions. It thus provides an overall legal framework for key elements of the care and treatment of people lacking in mental capacity to make decisions about their own care and treatment.			
Target audience (policy relevant to)	All services			
Links to other policies	Consent to Treatment or Examination Policy Deprivation of Liberty Safeguards Policy Advance Decision to Refuse Treatment and Advanced Statement Policy			
Version control	Status	Version	Approval date	Review date
	V001	Final	02.04.2015	April 2018

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Contents

1 Introduction

1.1 The question of whether a service user has the mental capacity to make a decision regarding their treatment or care is fundamental to health services as for service users the having of such capacity is the precondition for giving valid consent to care or treatment. What is meant by mental capacity and when and how it should be assessed are given statutory definition and authority for those aged 16 years or above by the Mental Capacity Act 2005 (MCA).

1.2 This policy has arisen from the implementation of the MCA 2005 and seeks to give advice and guidance on how and when an assessment of mental capacity should be carried out. It draws a distinction between routine/ongoing assessments of capacity, which is a part of everyday care, and more exceptional occasions, when a formal assessment is necessary. In the latter case a formal, documented assessment is now required by the Trust in defined instances (see 7 below).

1.3 Although this policy is a local interpretation of the MCA 2005 by this Trust, much that is in it reflects a broader legal position and accepted principles following the implementation of the MCA 2005. In particular assessments of capacity do not become necessary solely in mental health and/or learning disability services, but occur in all health and social care settings (community inpatients, rehabilitation beds, District Nursing etc).

2 Aims and Objectives

2.1 This policy aims to embody the principles of the MCA 2005 in the clinical practice of the Trust.

2.2 It also aims to provide an easily accessible summary of those parts of the MCA 2005 relating to the assessment of mental capacity and making best-interest decisions where patients are assessed as lacking capacity.

2.3 It aims to define when formal assessments of mental capacity are necessary and to provide a standard format for carrying out and recording them.

2.4 It takes account of the Deprivation of Liberty Safeguards (DoLS) now attached to the MCA 2005.

3 Definitions

Mental Capacity Act 2005 (MCA) – The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose mental capacity.

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

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

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

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

4 Roles and Responsibilities

4.1 Chief executive
The Chief executive has accountability for ensuring the provision of high quality, safe and effective services within the Trust.

4.2 Executive Directors
Executive Management Team (EMT) are responsible for ratifying all policies and strategies.

4.3 Trust Secretary
Is responsible for ensuring the executive lead signs off all policies after AD approval before presentation to EMT for ratification (note: procedures/guidelines and protocols do NOT require EMT approval).

4.4 Senior Leadership Team (SLT)
Responsible for the approval of all procedures/guidelines/protocols.

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

4.6 Assistant Directors
All assistant directors have a delegated responsibility for ensuring that this policy is known to all staff and that its requirements are followed by all staff within their area.

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

4.8 Staff
Responsible for:
- adherence to this policy
- ensuring any training required is attended and kept up to date
- ensure any competencies required are maintained
- co-operating with the development and implementation of policies as part of their normal duties and responsibilities
- identifying the need for a change in policy as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly
- identifying training needs in respect of policies

4.9 Authors
Responsible for writing the policy, sending out for consultation and making all amendments prior to final sign off.

4.10 Quality and Patient Safety
Responsible for:
- quality checking all documents to ensure both statutory and Trust requirements are met (this is to be carried out via stakeholder consultation)
- publishing approved/ratified/amended documents on NELFT's internet
- communicating newly approved/ratified/amended documents to Communications for publication in Team Brief

4.11 Communications
Publishing an article in the Team Brief indicating all newly approved/ratified/amended documents

4.12 All Health Professionals
All frontline health professionals have a responsibility for assessing the mental capacity of patients they are responsible for and making best-interest decisions where they lack the capacity to do so.

4.13 Consultant Doctors
Consultant doctors have a particular responsibility to carry out assessments of capacity in border-line and other difficult cases, especially when specifically asked to do so by staff, and in some set situations such as when requested to do so by the Court of Protection.

4.14 Mental Health Law Manager
To give advice to staff about the use of the MCA to assess capacity.

4.15 Safeguarding Adults Team
To give expert advice to staff about the use of the MCA to assess capacity, assessable via the Safeguarding Adults Duty Desk Monday – Friday (excluding Public Holidays) 09.00-17.00 0300 555 1201 EXT: 64715 and safeguarding.adults2@nelft.nhs.uk

5 Process

Principles of Mental Capacity Act

5.1 Section 1 of the MCA sets out five principles to be followed in working with people who may lack capacity. Because these are embodied in the MCA they are statutory principles and have a corresponding authority. They must be followed at all times when the MCA is being used, including assessment of capacity.

5.2 **The principles in Section 1(1) are as follows:**

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes a decision that others believe to be unwise.
4. An act done or decision made, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before such an act is done, or decision 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 invasive or restrictive of the person's rights and freedom of action.

6. Assessment of Mental Capacity

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

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

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

6.4 As a health Trust, NELFT is most frequently involved in assessment of capacity in relation to day-to-day treatment decisions. However note that the MCA and therefore this policy can relate to decisions about social care, finance, safeguarding and problems in other non medical/health areas.

7 When Mental Capacity should be assessed

7.1 Care and treatment, is often a matter not just of one-off treatment such as an operation or other medical intervention, but of on-going care over a period of years. The assessment of capacity must therefore be a continuous and ongoing process informed by the principle (see above 4.2) that a person is to be assumed to have capacity until it is established otherwise. All professionals involved in the provision of care and treatment must assure themselves either that the person continues to have capacity or that where they do not, the care and treatment given is necessary and in the person's best interests in compliance with the MCA code of practice (2007) Section 5.

7.2 It is helpful and best practice for the routine assessment of capacity to be noted in the clinical progress notes.

7.3 Where the person has been admitted to hospital there should be a detailed, documented assessment of their capacity to consent to the care and treatment being offered. This should be written in clinical notes e.g. *RiO* or *SystmOne*.

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

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

- Informal admission to hospital.
- Consideration or use of Safeguarding Procedures.
- Serious medical treatment (as defined by the Mental Capacity Act 2005) S.37(6).
- Significant change of accommodation (as defined by the Mental Capacity Act 2005) S.38 and S39.
- Necessary breach of confidentiality (i.e. where personal information about the service user may be given to a third party).
- Important decision in relation to the management of finances, property or affairs.
- Any situation where consideration is being given to a referral under DoLS.

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

7.6 In line with 5.1 above, the assessment should be carried out by the professional identified as responsible for the decision in question, but in more difficult cases specialist assistance should be obtained e.g. from a psychiatrist.

7.7 Where a second, perhaps more specialist, professional has been involved in the assessment, their views should be taken into account, but the ultimate decision about capacity remains with the professional responsible for the treatment/other decision.

8 Demonstrating Decision-making Capacity

8.1 Mental Capacity is now given a statutory definition in the Mental Capacity Act, Section 2. This states that to be considered as lacking capacity in relation to a decision a person must have some form of impairment of or disturbance in the functioning of the mind or brain which results in an inability to make the specific decision at that time.

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

In order to demonstrate decision-making capacity, a person should be able to:

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

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

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

8.5 Note that the process of decision-making must be free from outside interference. A decision to receive a specific treatment that is the result of undue pressure or coercion is not freely made and any consent obtained in this way may be invalid (see Mental Capacity Act Code of Practice 23.31).

9 Determining an individual's best interests

9.1 All decisions and actions taken on behalf of a person who lacks capacity must be taken in the reasonable belief that they are in the person's best interests. This is one of the principles of the MCA (Section 1(5) – see above 4.2).

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

- Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question. (In which case all but

urgent decisions can be deferred until the person regains capacity to make the decision themselves).

- The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence them if they had capacity.
- The need not only to allow but to encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her.
- The views of relatives, carers or other people involved whom it is appropriate and practical to consult about the person's wishes and feelings, and what would be in his or her best interests.
- Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action, (see point 5 in 4.2 above).
- In the case of medical treatment, that treatment should be necessary to save life, prevent deterioration or ensure an improvement in the person's physical or mental health and should be consistent with a reasonable body of current medical opinion (the "Bolam" test).
- It is not possible to make a best-interests decision that someone should get married, divorced, enter into a sexual relation, have a child adopted, discharge parental responsibility or vote in an election, (see MCA, Section 27).
- Best Interests decisions cannot over-ride a valid Advance Decision.
- In some cases, it will be in a person's best interests to be referred to safeguarding adult procedures as an adult at risk of abuse.
- In relation to 16 & 17 year olds deemed to be Fraser competent, the principles set out in Section 1(1) of the MCA and listed in section 5.2 of this policy should be applied. However, it must also be considered that as defined by the Children Act 1989, 16 & 17 year olds are classified as children. If there are concerns of a safeguarding nature, the NELFT Safeguarding Children Operational Policy should be referred to and acted upon in line with local authority safeguarding children procedures.
- A Best Interests decision cannot be made that someone should take part in Research.

9.3 Where necessary Best Interests decisions should be documented on the Assessment of Mental Capacity Form, if used (see Appendix 2).

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

10 Referrals to Independent Mental Capacity Advocates (IMCAs)

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

- A patient or other lacks capacity to make at least some important healthcare decisions for more than a purely short term period.
- The patient does not have relatives, carers or friends who can be consulted (this might include instances where there is a known relative, but they are not involved with or concerned about the patients care).

- A decision needs to be made about serious medical treatment provided by the NHS and not covered by Part IV of the Mental Health Act 1983.
- A significant change of accommodation is proposed by a NHS body or Local Authority, for example to a residential or nursing home or to another hospital and this change is not taking place under the MHA 1983.

11 Sharing/Communicating Information

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

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

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

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

12 Implementation process

12.1 Staff will be made aware of any new approved policies/procedures/guidelines via the monthly team brief. Quality and patient safety team will be responsible for ensuring newly approved documents are sent to the communications team in order for them to insert into the team brief.

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

13 Monitoring Process

13.1 The Mental Health Law Group will be used as a focus to discuss and resolve issues relating to the assessment of capacity.

13.2 Periodic audits of the assessment of capacity will be carried out, looking particularly at individual patient case notes, to examine whether this policy is being adhered to in practice. The results will be considered at the Mental Health Law Group.

Monitoring table

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Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Recommendations	Learning lessons
The compliance of MCA Training	Integrated Care Directors	Dashboard data will be provided by Education and Training and monitored at QSC.	Monthly	Quality and Safety Committee	Integrated Care Directors to monitor compliance and monitor compliance.	
Monitoring of issues relating to the assessment of Mental Capacity	Robert Keys	Mental Health Law Act Group	Quarterly	Mental Health Act Group	Operational Leads in attendance to action recommendations from the group as appropriate	
Audits of assessment of capacity will be carried out, looking particularly at individual patient case notes, to monitor adherence to the policy	Safeguarding Adults Team	Mental Health Law Act Group/ Safeguarding Groups	Quarterly	Report Presented at Mental Health Law Act Group/ Directorate Safeguarding group meetings	Operational leads to action audit recommendations and findings.	Lessons learned shared through aggregated learning, supervision, team meetings and feed into the delivery of training by the Safeguarding Adults Team.

14 Equality Statement

This policy recognises that there is a potential for procedures relating to the assessment of capacity and best interests decision making to be affected by minority groups. This could be either black ethnic minority groups or others such as people with learning or other disability. The intention of this Trust is that the Policy should be equally applied so that, for example, people from black ethnic minority groups are not more likely than others to be seen as lacking in capacity. It is also the intention that disabilities should not in themselves be seen as equating to lack of capacity. This is, in fact, in accord with the principles of Section 1 of the Mental Capacity Act itself. Equal use of this policy for different groups will be specifically considered in the monitoring arrangements under 11 above.

15 External references

There is a wealth of published advice and guidance on assessment of mental capacity. This Trust Policy is intended to assist professionals in making an assessment; it is not intended to replace any of the published guidance. Some key sources of further advice include:

- Mental Capacity Act 2005 http://www.dca.gov.uk/menincap/legis.htm
- Mental Capacity Act Code of Practice, 2007
- Deprivation of Liberty Safeguards: Code of Practice to supplement the main MCA 2005 Code of Practice, 2008
- Assessment of Mental Capacity. Guidance for Doctors and Lawyers (Second Edition, 2004). The British Medical Association and The Law Society. BMJ Books
- Guide to Consent to Treatment – Medical Defence Union (1999) http://www.the-mdu.com/associatedArticles/consent.pdf
- Mental Health Act Code of Practice, 1999, Chapters 15 and 16

16 Training

16.1 The Trust will regularly provide training on the Mental Capacity Act for all levels of staff who work with it. This will include areas covered by this Procedure, such as the principles of the MCA, assessment of capacity, best interest decisions and DoLS.

16.2 The Trust will also commission training as necessary on aspects relating to this Procedure, such as assessment of capacity as required.

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Stakeholder form

Stakeholder title	**Date sent to Stakeholders:** 21/3/2014	**Comments received**	**Returned, no comments**
Equality and Diversity Manager	Harjit K Bansal	✓	
Leadership Team – Basildon and Brentwood Locality	Brid Johnson		
Leadership Team – Barking and Dagenham Locality	Gill Mills		
Leadership Team – Havering Locality	Caroline O'Donnell		
Leadership Team – Redbridge Locality	Bob Edwards		
Leadership Team – Thurrock Locality	Michelle Stapleton		
Leadership Team - Waltham Forest Locality	Sue Boon		
Compliance Team (QPS policies@nelft.nhs.uk)	Alison Noll	✓	
Mental Health Law Manager	Robert Keys	✓	
Named Nurses Safeguarding Adults	Chelle Farnan Helen Bowman	✓	
Associate Director Safeguarding Children	Catherine Webb	✓	
Named Nurses Safeguarding Children	Helen Gregory Keri Clay Marie Fitzpatrick Belinda Coates Jacquie Pridie Debbie Xavier	✓	

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INITIAL SCREENING EQUALITY IMPACT ASSESSMENT FORM

Directorate/Department	**Safeguarding**
Name of Policy/Service/Function	**Assessment of Mental Capacity**
New or Existing Policy/Service/Function?	**Existing**
Name and role of Person completing the EQIA	**Harjit Bansal**
Date of Assessment	**4 March 2015**

		Yes/No	What/Where is the Evidence to suggest this?
1	**Does the Policy/Service/Function effect one group less or more favourably than another on the basis of:**		There is considerable evidence that some protected groups are at higher risk of developing mental health problems, have lower wellbeing and may have reduced access to, a different experience of, and outcome from a range of mental health services.
	• Race, Ethnic origins (including, gypsies and travellers) and Nationality		Suicide rates are particularly high among younger black men and unemployed men. African-Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act and are disproportionately represented in secure units. Although these findings relate to BME communities, they are also relevant to the wider population. Factors that facilitate recovery were identified as: support from family and friends, 'keeping busy', a positive attitude, faith and religion, and medication. Lack of support from family and friends, the stigma of mental illness, a return to an unchanged environment after treatment, a poor experience of treatment, and disbelief that recovery is possible, were seen as obstacles to recovery. There is a higher rate of poverty among minority ethnic communities, which is on average twice as high as for the White British population. Over half of Bangladeshi, Pakistani and Black African children in the UK grow up in poverty. Taken together, these facts suggest that the impact of inequality on adult and child mental health among minority ethnic communities is particularly high. It is vital that service users/carers whose first language is not English are able to understand what mental capacity is and having access to leaflets/information that is made available in a format that supports the patients/carers understand of the act. There may be cultural issues with consent which will need to be

			understood and assessed.
	• Gender (males and females)		Rates of mental health problems are generally higher in boys compared to girls. They are also exposed to different experiences, for example, rates of sexual abuse. Men and women also have different rates of mental health problems. The different pattern of mental health problems across the sexes is explicitly recognised Women are at greater risk of anxiety disorders, eating disorders, self-harm and sexual, emotional or physical violence, which are associated with higher rates of mental health problems. One in four women requires treatment for depression at some time. Post-natal depression affects a significant minority of women. If it is left undiagnosed and untreated, it can result in significant harm not just to women, but also to their children and wider families. Fewer men seek treatment for depression, which may in part reflect men's fear of stigmatisation than to be an accurate indicator of the incidence of male depression. Male mental distress is more likely to result in violent behaviours towards self and others, so that men are three times more likely to die from suicide than women. Alcohol dependence in past 6 months is 1.4 times more common in men and 2.0 more common in women from the highest 20% household income compared to the lowest 20%. Dependence on any drug is 4.6 times more common for men and 33 times more common in those from lowest 20% household income compared to top 20%. Decisions should be carefully considered when there is potential domestic abuse and issues regarding vulnerability.
	• Age		Mental health problems affect all aspects of a child's life, including educational achievement, physical health and social functioning. They also have serious repercussions on the life of

			the family and the community. Children with poor mental health suffer poorer outcomes across a range of factors in later life, including a high risk of mental illness and of continuing to live in poverty. Particular striking features are that children and young people with conduct disorder are 17 times more likely to be excluded from school and four times more likely to be two or more years behind in intellectual development. Those with emotional disorders are almost five times more likely to self-harm or commit suicide, and are over four times more likely to be in poorer health or to have long periods of time off school. 35% of people with mental health problems are over 65, their mental health problems are often associated with poor physical health and social isolation. However, mental health problems including depression among older people is less often diagnosed or treated promptly in primary care with only 15% of older people with depression discussing their symptoms with their general practitioner and less than half of these receiving adequate treatment. Dementia is also a key mental health issue for older people. It affects five per cent of people over the age of 65 and 20 per cent of those aged over 80. However, only a third of cases of dementia are currently ever diagnosed, meaning opportunities to minimise harm and promote good life quality are not taken.
	• Religion, Belief or Culture		To improve outcomes for all people it will be necessary to incorporate religion and belief into the assessment of all individuals. Evidence suggests that having religious or other beliefs can be associated with better mental health.
	• Disability – mental, physical disability and Learning difficulties		A number of individuals with other disabilities e.g. learning disability have higher rates of mental health problems. Services should be accessible by all people with disability including for example those with a sensory impairment. It makes the explicit recommendation that all people with learning disability and autism will have access to mainstream services. Ensure systems are in place for them to access BSL, large print, braille and other formats of information as requested.

	• Sexual orientation including lesbian, gay and bisexual people		LGBT people are at significantly higher risk of poor mental health compared to heterosexual people. There is evidence to recognise the higher rates of some mental health problems in lesbian, gay and bisexual people. A priority for action is to improve monitoring of access to services and experience and outcome by sexual orientation. This will enable local services to understand whether prevention and promotion services are being appropriately accessed.
	• Married/or in civil partnership		Evidence suggests being married is associated with better mental health. There is less evidence on the benefits of being in a civil partnership; however, there is evidence that being in a good supportive relationship is beneficial for mental health. It is crucial to address this as part of the assessment process, and those with no partners to support, than support mechanisms should be explored e.g. third sector.
	• Pregnant/maternity leave		There is evidence to suggest that teenage pregnancy is highest in the UK, and prevalence of post-natal depression for women in general. Systems are in place to improve pre- and post-natal care for mothers, especially teenage mothers and should also address the needs of those at significant risk of developing mental health problems
	○ Transgender reassignment		More than one in three people who are described by the Equality Act 2010 definition of gender reassignment have attempted suicide. Transsexual people may suffer considerable discrimination. They are at higher risk of mental health problems including alcohol and substance misuse, suicide and self-harm.
2	**Is there any evidence that some groups are affected differently? Is the impact of the policy/Guideline likely to be negative?**	Yes	As mentioned above.
3	**Is there a need for additional consultation e.g. with external organisations, service Users and carers, or other voluntary sector groups?**	Yes	Staff & carers and voluntary sector organisations supporting patients who lack capacity.
4	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	Yes	
5	**Can we reduce the impact by taking different actions?**	Yes	- Ensure patients/carers have access to information leaflets in different formats and languages. - Improve diversity monitoring of all patients to

			explore trends and improve outcomes. - Regular audits to assess the implementation of the policy.

Assessor's Name: **Date:**

Name of Director:

This section to be agreed and signed by the Equality and Diversity Manager in agreement with the Equality and Diversity Team

Recommendation
Full Equality Impact Assessment required:

NO ✓ YES □

Assessment authorised by:

Name: **Harjit K Bansal, Equality and Diversity Manager**

Date: **4th March 2015**

North East London NHS
NHS Foundation Trust

Approval Checklist – for the Review and Approval of Policy and Operating Procedures or Guidelines

To be used as a guide to quality check that Policy and Guideline practice has been implemented before submitting for approval. If you have answered "No" to any of the questions, your document will NOT be accepted for ratification

	Checklist	Yes/No	Comments
1	Does your document follow the current template for Policies/Procedures/Guidelines available on the Trust website?	yes	
2	Is the title clear and in the correct style and format (Arial font size 11, left justified throughout)?	yes	
3	Are all paragraphs and sub-paragraphs numbered? Have bullet points been used appropriately, i.e. only for short lists and not in place of paragraphs?	yes	
4	Is the front sheet fully completed?	yes	
5	Does it have the correct version number?	yes	
6	If this is a clinical adult guideline check to see if listed in Royal Marsden on-line manual. If so can Royal Marsden guideline be used? On-line manual accessed via Trust Intranet	yes	
7	CQC – Does your policy/procedure/guideline reflect the criteria within the CQC's 5 Key questions - that services deliver Safe, Caring, Responsive, Effective and Well led care?	yes	
8	Is the monitoring process clearly described and monitoring table within template complete?	yes	
9	Any training aspects of policy/procedure identified? Follow-up procedures listed.	yes	
10	Does this document link to any NELFT policies? Are they listed on document control sheet?	yes	
11	Are the references listed up-to-date and appropriate?	yes	
12	Have you carried out a robust stakeholder process, ensuring those listed in the template as stakeholders are consulted and is the stakeholder form comment box complete?	yes	
13	Is the Equality Impact Assessment tool fully completed, individualised to this document and approved - have you received a signed authorised copy back from Equality and Diversity team?	yes	
14	If you have attached appendices are they appropriate, referred to within the document and listed on contents page?	yes	
15	Regarding HR policies – have they been signed off by the Joint Negotiating Consultative Committee (JNCC) prior to submission to the ratification process?	n/a	
16	Finally have you carried out a final proof-read, checked all spellings and ensured your document is accurate and ready for publication?	yes	

Appendix 1

Guidance for Assessing Mental Capacity

All persons (16 and over) are presumed to have capacity. Therefore assessments of capacity must only be conducted where there are doubts about an individual's ability to make a specific decision, or consent to a specific action.

The only way to prove a lack of capacity is by carrying out a capacity assessment.

The assessor must be a registered qualified professional and where possible have an established relationship with the individual.

Capacity should be judged in relation to a specific decision – some decisions are easier to make than others, i.e. a service user may be able to make some but not other decisions.

A mentally capable adult has an absolute right to refuse to consent to any intervention or medical treatment for a physical condition for any reason, rational or irrational, or for no reason at all, even where this decision may lead to his or her own death.

PRINCIPLES OF ASSESSING MENTAL CAPACITY (MCA, SECTION 1)

7. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
8. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
9. A person is not to be treated as unable to make a decision merely because he or she makes a decision that others believe to be unwise.
10. An act done or decision made, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
11. Before such an act is done, or decision 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 invasive or restrictive of the person's rights and freedom of action.

Care should be taken to ensure that all practicable (do-able) steps are taken to facilitate an individual's optimum performance in this assessment; including provision of communication aides. Where an interpreter is required, this should be a professional interpreter.

Remember that you must **evidence** your findings in each question – for example, how did you *know* that the individual could/couldn't understand the information you gave them? What did they say / do to make you reach that conclusion?

DEMONSTRATING DECISION-MAKING CAPACITY

In order to demonstrate decision making capacity, a person must be able to: -

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

A person who fails any one of the above four points is lacking in capacity in relation to that decision at that time.

DETERMINING AN INDIVIDUAL'S BEST INTERESTS

If the individual does not have capacity, they cannot consent; therefore decisions about proceeding will need to be made on the basis of the individual's best interests. Consultation must occur where appropriate with any person holding Lasting Power of Attorney; Enduring Power of Attorney, Court Appointed Deputy, IMCA, Family & friends.

Decisions made by the Decision Maker in an individual's **best interests** must be the **least restrictive** possible.

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

- Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question, (in which case non-urgent decisions may be deferred).
- The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence him or her if he or she had capacity.
- The need to allow and encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her.
- The views of relatives, carers or other people involved whom it is appropriate and practicable to consult about the person's wishes and feelings, and what would be in his or her best interests.
- Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action.
- In the case of a medical treatment, that treatment should be necessary to save life, prevent deterioration or ensure an improvement in the patient's physical or mental health and should be consistent with a reasonable body of current medical opinion (the "Bolam" test).
- The views of an IMCA/other advocate if appointed.

The MCA provides legal protection from liability for carrying out care if:

- The principles of the MCA have been observed
- The decision maker can demonstrate they assessed capacity
- The decision maker reasonably believes the person lacks capacity with regard to the decision
- The decision maker reasonably believes the action is in the best interests of the person

Ordinarily a person representing the interests of the person should be consulted before making a decision. However, in emergency situations it will be often in the best interests of the person to provide urgent care without delay.

If there is a dispute then it should be clearly identified. If there is a dispute then the following things can assist the decision maker:

- Involve an advocate who is independent of all parties involved
- Get a second opinion
- Hold a case conference
- Go to mediation
- An application can be made to the Court of Protection for a ruling

Referral to IMCA's

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

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

Definitions of Serious Treatment

Serious medical treatment is defined as treatment that involves giving new treatment, stopping treatment or withholding treatment where:

- If a single treatment is proposed there is a fine balance between the likely benefits and burdens to the patient and the risks involved
- A decision between a choice of treatments is finely balanced
- The treatment is likely to have serious consequences for the patient.

Decisions about whether treatment meets the above definitions may be difficult. It may be helpful to take as a guide that treatment should come within the definition if it is such that, if the patient was capable, their explicit consent would be sought. If the treatment is urgent, it should not be delayed to allow an IMCA to be appointed first.

The above does not apply if the treatment is for a detained patient and is covered by Part IV of the MHA.

Definitions of Significant Change in Accommodation

A significant change in accommodation is where one of the following apply to someone who lacks capacity to consent to the change:

- A NHS body is proposing to admit the person to a hospital and they are expected to be there more than 28 days
- A NHS body or Local Authority is proposing to arrange residential accommodation and the person are expected to be there for more than 8 weeks.

In both cases it is possible to admit the person to the hospital or care home first and then refer the person to an IMCA i.e. the admission/placement should not be delayed solely to allow an IMCA to be appointed.

The function of an IMCA

The IMCA service is a statutorily funded advocacy service introduced by the MCA and further developed by regulations. It is separate from other advocacy services (though it may sometimes be run under their aegis) and IMCAs must receive specialist training in the MCA and working with people who lack capacity. The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and significant changes of accommodation. An IMCA is someone instructed to support and represents a person who lacks capacity to make some serious decisions. In order to do this they will:

- Confirming that the person instructing them has the authority to do so
- Interviewing or meeting the patient in private
- Examining any relevant records, including paper or electronic clinical notes
- Obtaining the view of professionals and other paid staff
- Obtaining the views of anybody else who can give information about the wishes and feelings, beliefs or values of the patient
- Finding out what the alternative treatment or care options might be
- Considering obtaining another medical opinion if that would help the patient
- Writing a report of their findings for the NHS or local authority.

An IMCA has a right to challenge any decision about the patient's current or planned care or treatment and whether it is in the patient's best interests.

Where an IMCA will not be allocated

The IMCA cannot be instructed if:

- A patient who now lacks capacity previously named a person who should be consulted about decisions that affect them, and that person is available and willing to help
- The patient has appointed either an Enduring Power of Attorney or a Lasting Power of Attorney
- The Court of Protection has appointed a deputy to act on the patient's behalf

Responsibility for Making Referrals

8.1 The MCA does not specify who needs to make the referral to the IMCA and statutorily it is enough that the referral is made.

8.2 The Trust will consider the need for referral to an IMCA as part of the assessment process following referral and again following admission to hospital, or at subsequent CPA meetings.

8.3 The responsibility for making the referral will be delegated to the appropriate member of staff, which will usually be the Care Co-ordinator (Community) or Named Nurse (in Hospital).

8.4 See Appendix 2 for a standard referral form, though this is not required and referral can be made in other forms.

8.5 Any referral must be documented in the Clinical Notes/RIO.

LOCAL IMCA SERVICES

Patients should be referred to the IMCA service for the area in which their home/ hospital/unit/care home is situated.

Appendix 2

**ASSESSMENT OF MENTAL CAPACITY
and DETERMINATION OF BEST INTERESTS**

SUMMARY OF STEPS IN ASSESSING MENTAL CAPACITY

For further guidance please refer to: http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

1. Capacity should be judged in relation to a specific decision.
2. Some decisions are easier to make than others.
3. A mentally competent adult has an absolute right to refuse to consent to any intervention or medical treatment for a physical condition for any reason, rational or irrational, or for no reason at all, even where this decision may lead to his or her own death**.**

PRINCIPLES OF ASSESSING MENTAL CAPACITY

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes a decision that others believe to be unwise.
4. An act carried out, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before such an act is done, or decision 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 invasive or restrictive of the person's rights and freedom of action.

DEMONSTRATING DECISION-MAKING CAPACITY

In order to demonstrate decision making capacity, a person should be able to: -

1. Understand the information relevant to the decision, including the purpose of any proposed course of action, the main benefits, risks and alternatives, and the consequences of refusing to follow the proposed course of action and of failing to make a decision.
2. Retain that information for long enough to make a decision.
3. Use or weigh that information as part of the process of making the decision.
4. Communicate his or her decision, whether by speech, sign language or any other means.
5. A person who fails any one of the above four points is lacking in capacity in relation to that decision.

DETERMINING AN INDIVIDUAL'S BEST INTERESTS

In determining what is in a person's best interests, regard should be made to medical and welfare issues, and the religious, cultural and ethical principles of the person.

The following must be considered: -

1. Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question.
2. The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence him or her if he or she had capacity.
3. The need to allow and encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her.
4. The views of relatives, carers or other people involved whom it is appropriate and practicable to consult about the person's wishes and feelings, and what would be in his or her best interests.

5. Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action.
6. In the case of a medical treatment, that treatment should be necessary to save life, prevent deterioration or ensure an improvement in the patient's physical or mental health and should be consistent with a reasonable body of current medical opinion (the "Bolam" test).
7. The views of an IMCA/other advocate if appointed.

Patient Details		
Patient's Name:	NHS Number:	
Ward:	Consultant:	
Patient's home address and Postcode:	Date of birth:	
Date of Assessment: :	Date of any previous assessment of capacity:	
Details of treatment decision, or other specific issue in relation to which capacity is being assessed:		
Assessor/s details		
Name:	Email address:	
Role:	Phone no. and Bleep:	
Patient Mental Capacity Assessment		
Does the patient have a permanent or temporary impairment/disturbance in the functioning of the mind or brain?	**Yes**	**No**
If yes, give a diagnosis or brief description:		
In relation to this decision/issue please answer the following questions: **Please note that if the service user fails the test at any point, they lack capacity in relation to the decision at the time of the assessment**		
Can your patient understand the information relevant to the decision? Comments:	**Yes** ☐	**No** ☐

Can your patient retain the information long enough to make the decision? **Yes** ☐ **No** ☐
Comments:

Are they able to weigh the information in the balance in order to make a decision? **Yes** ☐ **No** ☐
Comments:

Can your patient communicate the decision by any means? **Yes** ☐ **No** ☐
Comments:

Following assessment has this person been found to have mental capacity to make this decision?

☐ **Yes** ☐ **No**

If the person has been found to <u>have</u> mental capacity in relation to this matter, their decision should be respected and you are not required to proceed to the next section of the form.

Is your patient likely to recover capacity? If yes, the assessment of capacity should be repeated at a future point	**Yes**	**No**

Suggested time-interval before further assessment required:

Has this person appointed a Lasting Power of Attorney? If so provide details: **Yes** ☐ **No** ☐

Name: Relationship: Contact details:

Does your patient have any relatives or friends who can contribute to a best interest decision? If so provide details below:

Name: Relationship: Contact details:

Name: Relationship: Contact details:

If the person has no friends or family, please request the input of an IMCA if the decision to be made relates to a **significant** change in residence; Deprivation of Liberty application; or when a **significant** medical decision is being considered.
(Refer to NELFT MCA Policy when determining what is considered "significant")

Has a valid and applicable Advance Decision to Refuse Treatment been made in relation to the proposed treatment or care?

☐ **Yes** **No** ☐

If you have answered "yes", a best-interest decision is not required and the Advance Decision should be respected if found to be both valid and applicable. (Consult NELFT policy on Advance Decisions to Refuse

Treatment and Advance Statements)

Referral to IMCA

Date of referral

Determination of Best Interests
If the outcome of the assessment is that the service user lacks capacity, it may be possible to treat/act in their best interests. To help determine this please consider the following questions

	Yes	No
Have the service user's past and present wishes and feelings been considered as far as possible? Have any Advance statements been considered? **Comments:**	☐	☐
Have the service user's known beliefs and values been considered? ☐ ☐ **Comments:**	☐	☐
Have the service user's relatives/friends been consulted**?** **Comments:**	☐	☐
Is there an IMCA/other advocate involved? If yes, have their views been considered? **Comments:**	☐	☐
Is there a lasting Power of Attorney/Deputy appointed by the Court of Protection? Have they been consulted? **Comments:**	☐	☐
Is the person subject to a DOLS authorisation? **Comments:**	☐	☐

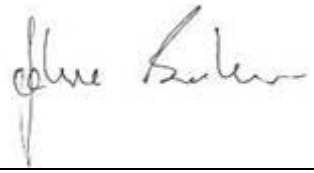
Proposed course of action and reasons

Completed by: Name: Position: Date:

North East London NHS
NHS Foundation Trust

EMT APPROVAL SHEET

Policy title:	Assessment of Mental Capacity Policy
Author:	Susan Smyth – Interim Director of Nursing (Clinical Effectiveness) Linked to Barts Health Economy
Lead Executive Director approval	Trudie Rossouw, Interim Medical Director

Meeting	Date of meeting	Chair name and title	Signature of Lead Director/ EMT Chair	Approved? Y / N	Reason for non-approval
EMT	02.04.15	John Brouder, CEO		Y	

Once the form has been agreed/not agreed for ratification by the Executive Management Team the Trust Secretary should send to policies@nelft.nhs.uk as confirmation of approval

Addendum

Date	Section	Change	Agreed by