Policy:

NP 023 Capacity and Consent to Care, Support and Treatment

Executive Director Lead	Executive Medical Director
Policy Owner	Head of Mental Health Legislation
Policy Author	Head of Mental Health Legislation

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Summary of policy

A policy to describe duties, practice and standards in respect of assessing and recording capacity to consent to or refuse care, support and treatment.

Target audience	All staff involved in the delivery of care, support and treatment

Keywords	Mental Capacity Act , mental capacity, capacity, consent, care, support, treatment

Storage & Version Control

Version 7 of this policy is stored and available through the SHSC intranet/internet.. This version of the policy supersedes the previous version (V6 – Aug 2019). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
V5D0.1	November 2008 Policy out of date and requires review and update	March 2016	Review of current policy commissioned by EDG.
V5D0.2–0.5	Updated during consultation	June – September 2016	Amendments made during consultation, prior to ratification.
V5D0.6	Reformatted for new policy document template	October 2016	Re-formatted for new policy document template. Appendices updated.
V5	Ratification / finalisation /issue	November 2016	Ratification / finalisation / issue
V6	Full review in line with schedule	July 2019	• Full review of content: • Job titles and roles updated • Additional information in respect of recording of capacity and/or consent, removal of unnecessary content in respect of children (MCA does not have application for under 16s) Transcription onto current policy template • Re-drafted to follow the Statutory • Principles sequentially • Additional information added in respect of least restrictive options • Language amended in parts to reflect the wording of Statute or Code of • Practice • Clarification of the 3 factors necessary to conclude that capacity is absent, ie the answer to any one of the 4 capacity questions is no; there is an impairment or disturbance in the functioning of the mind or brain; the impairment or disturbance is the reason for negative response to one or more of the 4 capacity questions • Addition of information in respect of the shift from what in medical opinion is pertinent information to what would be pertinent information for a reasonable patient (Montgomery case)

V7	Full review and update as policy date expiring	Nov 22	• New Trust policy template used. • Policy leads and owners updated. • Grammatical corrections made. • Error with the Montgomery case referencing corrected. • More emphasis given to clarifying the different types of Powers of Attorney. • Reference to Social Work England added as a professional registration body. • Emphasis given to importance of completing CAT1 assessments prior to patient admission. • Error in relation to Property and Financial Affairs and their commencement corrected. • Caution added to not confuse lack of engagement to mean lack of capacity. • Causal nexus emphasised especially in relation to documentation. • Added: if there is concern about a person who holds a Power of Attorney, or is a Court Appointed Deputy, and them not acting in a person's best interests, then to raise as a safeguarding concern and bring to attention of Head of Mental Health Legislation (rather than referring to OPG directly)

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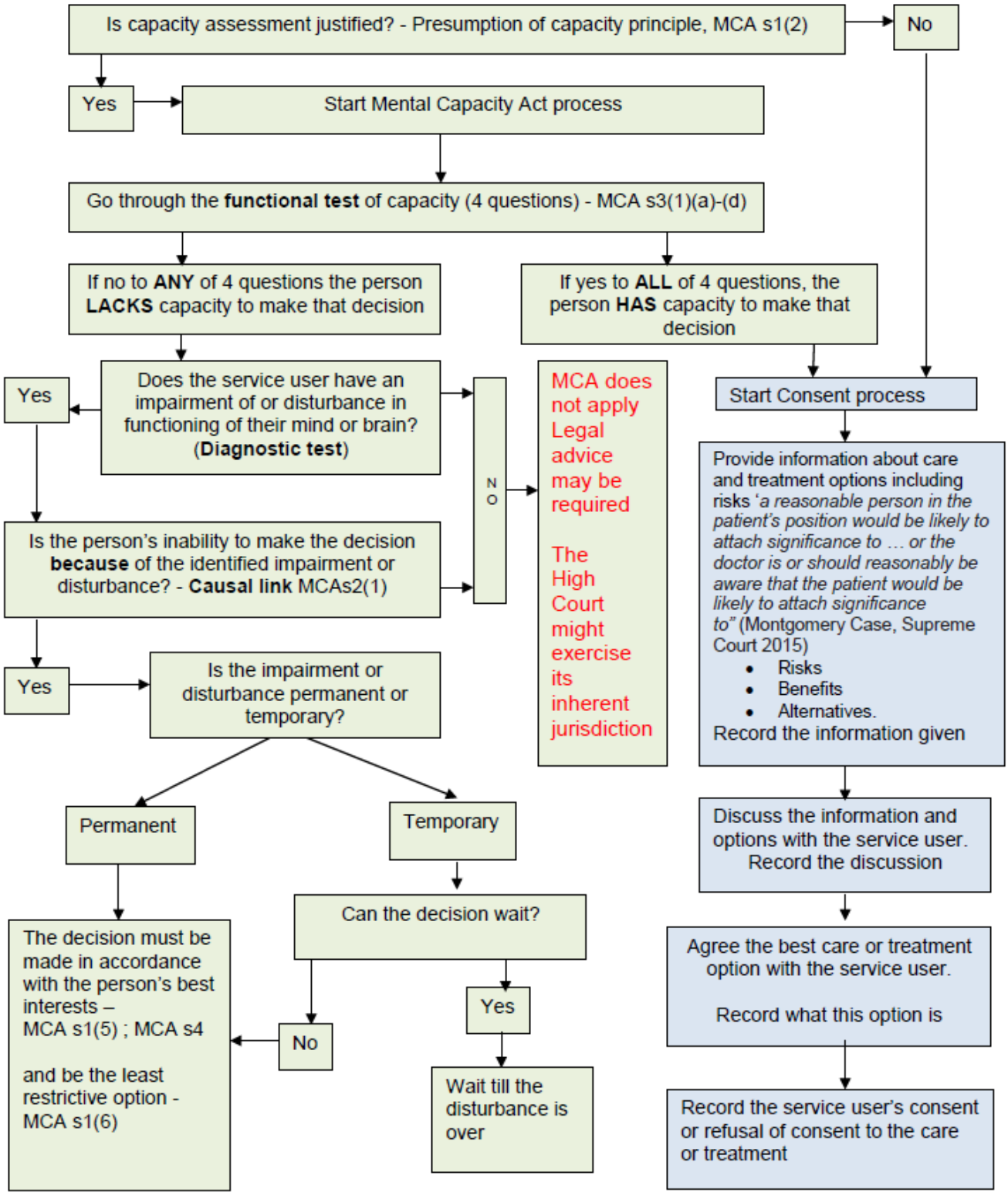
Flowchart


Is capacity assessment justified? - Presumption of capacity principle, MCA s1(2)
No
Yes
Start Mental Capacity Act process
Go through the **functional test** of capacity (4 questions) - MCA s3(1)(a)-(d)
If no to **ANY** of 4 questions the person **LACKS** capacity to make that decision
If yes to **ALL** of 4 questions, the person **HAS** capacity to make that decision
Yes
Does the service user have an impairment of or disturbance in functioning of their mind or brain? (**Diagnostic test**)
NO
MCA does not apply Legal advice may be required
The High Court might exercise its inherent jurisdiction
Start Consent process
Provide information about care and treatment options including risks '*a reasonable person in the patient's position would be likely to attach significance to … or the doctor is or should reasonably be aware that the patient would be likely to attach significance to*" (Montgomery Case, Supreme Court 2015)
• Risks
• Benefits
• Alternatives.
Record the information given
Is the person's inability to make the decision **because** of the identified impairment or disturbance? - **Causal link** MCAs2(1)
Yes
Is the impairment or disturbance permanent or temporary?
Permanent
Temporary
Discuss the information and options with the service user. Record the discussion
Can the decision wait?
Agree the best care or treatment option with the service user.
Record what this option is
Yes
No
The decision must be made in accordance with the person's best interests – MCA s1(5) ; MCA s4
and be the least restrictive option - MCA s1(6)
Wait till the disturbance is over
Record the service user's consent or refusal of consent to the care or treatment

1 Introduction

It is a legal and ethical principle that valid consent must be obtained before starting treatment, physical examination or investigation, or providing personal care. This principle reflects the right of service users to determine what happens to their own bodies and is a fundamental part of good practice. A worker who does not respect this principle may be liable both to legal action by the person and action by their professional body. Valid consent to treatment is, therefore, absolutely central in all forms of health and social care, from providing personal care to undertaking major surgery.

This policy reflects the Mental Capacity Act 2005 (MCA) and describes duties, practice, and standards in respect of assessing and recording capacity to consent to or refuse care, support and treatment for those who have mental capacity to decide for themselves, and how to proceed for those who lack mental capacity to make a particular decision at a particular time.

Employees of the Trust provide a diverse range of services in a wide variety of different contexts. In some situations, the process for obtaining valid consent is relatively straightforward. In other situations, this presents more challenges.

2 Scope

This is a trust-wide policy, with the exception of GP Practices. It applies to all health and social care staff working for the Trust, including those seconded in, those on fixed term or temporary contracts, or on the flexible/bank workforce. This policy should be read in conjunction with relevant updates in case law.

The MCA applies to persons who have attained the age of 16 years (with the exception of particular powers that are available only on attaining the age of 18 years).

It should be noted that this policy is specific to consent for care, support and treatment on living people, and the following areas are, therefore, not included:

- Consent to take part in research
- Consent to take part in audit/service evaluation
- Consent around information/data sharing
- The use of organs or tissues after death

In these situations, appropriate advice and guidance should be taken from other local and national documentation, as well as line managers/professional bodies.

With the exception of treatment for mental disorder being administered to a patient detained under a section of the Mental Health Act 1983 (as amended) (MHA) to which Part IV of that Act applies, or treatment administered to a patient subject to a Community Treatment Order under the MHA to which Part 4A of that Act applies, valid consent must be obtained and recorded in the care record for all aspects of care, support and treatment including:

- Medication and changes to medication;
- All physical interventions including surgery, anaesthesia and Electroconvulsive Therapy (ECT)
- All psychological interventions and therapies;
- Physical examinations;

- Physical investigations;
- Psychological testing;
- Personal care;
- Care plans of all types
- Informal admission under s131 MHA

Informed Consent for treatment ('Montgomery Test' – Montgomery Case, Supreme Court 2015)

In a move away from the 'reasonable doctor' to the 'reasonable patient', the Supreme Court's ruling outlined the new test:

> *"The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."*

In the case of medication, surgery and other medical interventions this should include a face-to-face explanation of the procedure and the risks, side-effects etc. This must include rare complications if they are relevant to the individual patient. It is not sufficient merely to provide a leaflet.

Although *Montgomery* addresses a surgical intervention, the principles also apply to other forms of treatment, such as psychological interventions.

If, after appropriate assessment, the person is found, on the balance of probabilities to lack mental capacity - to make the decision in question, then the assessment of this and the best interests decision (as appropriate) should be clearly documented.

3 Purpose

This policy sets out the legal and practice requirements for obtaining valid consent and gives guidance on the circumstances in which treatment may be given to a person who cannot give their valid consent.

This policy sets out the standards and procedures in Sheffield Health and Social Care NHS Foundation Trust. The aim is to ensure that all health and social care professionals are able to comply with the guidance and with legal requirements.

4 Definitions

'**Treatment**' - should be read to include physical or surgical treatments including Electro-Convulsive Therapy (ECT) medication, dietary (for example, Percutaneous Endoscopic Gastrostomy (PEG)), urinary care and also psychological therapies and interventions.

Medical treatment as defined in the Mental Health Act 1983 (as amended) and which may be given without consent under that Act includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care, the purpose of which is to alleviate, or prevent a worsening of, the disorder or any one of its symptoms or manifestations. Note that certain certification requirements need to be met.

Terms such as ‘procedure’, ‘intervention’ etc. may be used interchangeably throughout this policy

‘**Care**’ – means personal care such as assistance with bathing, using the toilet or eating.

‘**Care Plan**’ – a written document detailing how the person’s care will be provided.

‘**Worker’ ‘staff’ etc** – all health and social care staff working for the Trust, including those on fixed term or temporary contracts or on the flexible workforce. Please note that the terms staff, workers etc are used interchangeably throughout this document.

‘**Valid consent’** - For consent to be valid it must be given voluntarily by an appropriately informed person who has the capacity to consent to the assessment/intervention in question. The informed person may be the person her/himself, or a person who has authority under a Power of Attorney. Consent will not be legally valid if the person has not been given adequate information or where they are under the undue influence of another. Acquiescence where the person does not know what the intervention entails is not consent. Where a person does not have capacity to give consent, then assessment/treatment may be given lawfully providing it is given in accordance with the Mental Capacity Act 2005.

Patients merely signing a consent form is not by itself giving informed consent. Professionals will still need to be satisfied that a person has capacity to understand a particular issue when they sign such a consent.

‘Case law/common law’ – law developed by Judges through decisions in the Courts.

‘**Court of Protection’**- The specialist Court for all issues relating to people who lack capacity to make specific decisions.

‘**Lasting Power of Attorney’** (LPA)- A Power of Attorney created under the Mental Capacity Act appointing an attorney (or attorneys) to make certain decisions about another person. There are two types of Lasting Power of Attorney: Health and welfare, and Property and Financial Affairs. An LPA may only be granted by a person who has capacity to do so and who has attained the age of 18 years. In order to be valid, the LPA must be registered with the Office of the Public Guardian (OPG).

‘Court Appointed Deputy’ – An individual appointed by the Court of Protection to make decisions about Property and Financial Affairs and/or Health and Welfare for an individual.

‘Advance Decision to Refuse Treatment’ - A decision to refuse specified treatment made in advance by a person who has capacity to do so and has attained the age of 18 years. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. Specific rules apply to advance decisions to refuse life-sustaining treatment. Valid and applicable advance decisions are legally binding

‘**Capacity**’ – The ability to make one’s own decision about a specific issue, as defined by the Mental Capacity Act (2005).

‘Decision-maker’
Under the MCA, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the MCA Code of Practice as the ‘decision-maker’.

It is the decision-maker's responsibility to work out what would be in the best interests of a person who lacks capacity. A range of different decision-makers may be involved with a person who lacks capacity to make different decisions:

- For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.
- Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.
- Where nursing or paid care is provided, the nurse or paid carer will be the decision-maker.
- If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

5 Detail of the policy

This policy is concerned with statutory duties under the Mental Capacity Act 2005 and good practice in respect of assessing and recording evidence of capacity to consent as appropriate, and best interests decisions for those who lack capacity.

6 Duties

6.1 Trust Board

The Trust Board has ultimate responsibility and 'ownership' for the quality of care, support and treatment provided by the Trust. This includes the implementation of the Policy throughout the Trust and ensuring its effectiveness in the delivery of good practice with regard to consent. This is provided by:

- Demonstrating strong and active leadership from the top; ensuring there is visible, active commitment from the Board and appropriate board-level review of good practice with regard to consent;
- Ensuring there is a nominated Executive Director leading on the Board's responsibilities with regard to consent: for this policy - the Executive Medical Director
- Ensuring there are effective 'downward' and 'upward' communication channels embedded within the management structures; to ensure the communication of the need for all staff to assess capacity and obtain valid consent to care, support and treatment;
- Ensuring adequate finances, personnel, training, care records and other resources are made available so that the requirements of this policy can be fulfilled;
- Expecting all health and social care staff to play a part in the responsibility for meeting the requirements of this Policy;
- Maintaining accountability for good practice in consent through management roles and responsibilities.

6.2 Senior Managers and Directors, Clinical Directors, Heads of Service, Heads of Nursing, General Managers and Service Managers

These senior staff have responsibility for developing, implementing, and improving the Trust's policies and procedures as an integral part of day-to-day operations. They have a duty to

take all practicable measures to ensure that health and social care staff-assess capacity and always obtain and record valid consent to care and treatment. These include the following:

- Providing leadership and direction in regard to obtaining and recording valid consent;
- Ensuring staff receive training and supervision in consent;
- Ensuring the implementation of this policy is monitored through clinical audit, service user or staff surveys or other appropriate methods;
- Ensuring improvements are made to the staff performance on consent if needed;
- Ensuring suitable access, arrangements, IT provision and support and documentation are provided to enable staff to record consent in the care record.

6.3 Team, Ward and Matrons

Team, Ward Managers and Matrons have responsibility for:

- Ensuring the dissemination, implementation and monitoring of this Policy through existing staff forums;
- Ensuring all staff they manage always obtain and record valid consent to care and treatment;
- Ensuring all staff follow Trust policy and their professional regulatory body guidance on consent;
- Ensure that staff are conversant with the Policy and associated procedures and documentation and that they understand the importance of complying with its requirements;
- Ensuring consent is monitored through audits, staff surveys, service user surveys etc and taking active steps to remedy any deficiencies found;
- Allocating the necessary resources to achieve the goals of this policy.

6.4 Individual Employees

All health and social care staff working for the Trust have a responsibility to:

- Be mindful of the need to assess capacity in order to obtain and record valid consent to care and treatment, having regard to the Mental Capacity Act 2005 where appropriate;
- Become familiar with and abide by this Capacity and Consent to Care and Treatment Policy and all associated procedures, guidelines and documentation;
- Abide by the code of ethics and practice and associated guidelines on consent defined by their professional regulatory body e.g. GMC, NMC, HCPC, GPhC, SWE
- Undertake the relevant training around the Mental Capacity Act and consent, as required by the Trust;
- Undertake regular clinical supervision and/or seek advice on any areas of difficulty or complexity with regard to consent.
- Seek advice and report any concerns with regard to colleagues' ethical practice
- on consent to the appropriate manager or clinical supervisor.

7 Procedure

7.1 Statutory Principles

The Mental Capacity Act 2005 (MCA) applies when determining whether an individual has capacity to give their consent. There are 5 statutory principles in the MCA and it is therefore unlawful not to follow them:

- Principle 1: 'A person must be assumed to have capacity unless it is established that he lacks capacity.' (section1(2))
- Principle 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.' (section1(3))
- Principle 3: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision.' (section 1(4))
- Principle 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.' (section 1(5))
- Principle 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.' (section 1(6))

Furthermore, the MCA (section 2(3)) determines that an assessment that a person lacks capacity to make a decision must never be based simply on:

- their age
- their appearance
- assumptions about their condition, or
- any aspect of their behaviour.

Being diagnosed with a mental disorder does not necessarily mean that an individual lacks capacity to give or refuse consent or take any specific decision.

7.2 Seeking Valid Consent

Consent for any procedure or intervention should always be sought and recorded. In seeking valid consent to care and treatment, the member of staff must consider 2 questions:

- Having been given the necessary information, does the person have the capacity to give consent?
- Are they giving consent voluntarily and not under undue pressure?

7.2.1 Question 1: Does the Person Have Mental Capacity to Give or Withhold Consent?

When there is good reason to question the assumption of capacity (**Principle 1**) the MCA determines how capacity is to be established.

If it proves impossible, following formal assessment, to establish mental capacity (or lack of capacity) an application for determination of person's capacity may be made to the Court of Protection via the Trust's formal procedures.

The MCA states that a person lacks capacity if they are unable to make a decision for themselves in relation to a particular matter, because of an impairment of, or disturbance in functioning of, the mind or brain.

The presence of an impairment or disturbance in functioning of the mind or brain must not in itself be taken to imply that a person lacks capacity to make a particular decision.
Care should be taken to not assume that a person lacks mental capacity about a particular issue solely on the basis that they do not engage with the assessment process. The Courts have recognised that there is a difference between being unwilling to participate in an assessment, and being unable to. Where in doubt, advice can be sought from the Head of Mental Health Legislation.

7.2.1.1The Causal Link

If it is to be concluded that the person lacks mental capacity, their inability to make the decision, as demonstrated by a negative answer to one of the 4 questions detailed in MCA s3(1), must be because of, or arise from, the impairment or disturbance. The causal link must always be documented.

7.3 Establishing whether the person can decide for themselves

Assessing under the MCA whether the person has capacity is achieved by completing a 'functional test' of capacity as follows:

After having been given the necessary information in the most accessible manner possible, and all practicable steps have been taken to enable a person to make their own decision, **(Principle 2),** can the person:

- Understand information given to them relevant to the decision?;
- Retain that information long enough to be able to make the decision?;
- Use or weigh up the information to make the decision?;
- Communicate their decision (whether by talking, using sign language or any other means)

7.3.1 Understanding the Information

To give valid consent the person needs to understand in broad terms the nature and purpose of the decision to be made. Therefore, workers need to be aware themselves of the pertinent details necessary for the person to consent, ie the material risks, benefits and alternatives. However, the person need not understand all the details involved in the decision.

NB Where consent for Electro Convulsive Therapy is being discussed, workers should refer to the Trust's ECT Operational Policy and Procedures.

The use of information leaflets is considered to be an effective tool that can be used by workers to provide people with the information they need to help them to arrive at an informed decision. People can review the information after the consultation, which may prompt the person to ask further questions of the worker to more fully understand the treatment being proposed.

In this context, the use of information leaflets is considered by the Trust to be an example of best practice. The use of Easyread information in the leaflets which are specially written to assist people with learning disabilities and other cognitive impairments is also encouraged. If a person is given an information leaflet, a record of the name of the leaflet and version

number should be kept in their notes. Copies of leaflets (including version numbers) used by services should be centrally archived within those services.

However, workers must not regard the use of information leaflets as providing the person with all of the necessary information for the purpose of obtaining consent for admission, examination or treatment. The obtaining of consent is a process, which involves effective communication and dialogue between the worker and the person, and merely providing a person with an information leaflet will not meet the workers' obligations. Any person carrying out a procedure on a person must ensure that, immediately before the procedure, the person has understood the information and that they still give their consent. If the person has queries or concerns they must be given time to consider any additional information.

Although informing people of the nature and purpose of procedures may be sufficient for the purposes of giving valid consent as far as any legal claim of battery is concerned, this is not sufficient to fulfil the duty of care to the person. Failure to provide other relevant information may render the professional liable to an action for negligence if a person subsequently suffers harm as a result of the treatment received

7.3.2 Retaining the Information

There is no defined time period for retention of the information. The person needs only to be able to retain the information long enough to make the decision. This includes the process of using or weighing the information to reach a conclusion

7.3.3 Using or Weighing the Information

A person must be able to evaluate the information they have been given and use it to reach their decision. Establishing a person's ability to do so may be achieved by their engaging in a dialogue with workers, but staff must bear in mind that the person is not obliged to give reasons for their decision

7.3.4 Communicating the Decision

A person will not be deemed to lack capacity by the communication aspect of the functional test, unless they cannot communicate the decision by any means.

Care should be taken not to underestimate the ability of a person to communicate, whatever their condition. In some cases the difficulty may be because English is not the person's first language. Workers should take all reasonable steps in the circumstances to facilitate communication with the person, using interpreters or communication aids as appropriate and ensuring that the person feels at ease. In particular careful consideration should be given to the way in which information is explained or presented to the person. Where a family member or friend is used to communicate via a language other than English with the individual, it could place a burden on them to understand and interpret often complicated procedures, and the person may be more likely to come under undue influence. Using families or friends in this way is discouraged, except in urgent circumstances. Using an interpreter helps to ensure that a person's wishes are properly communicated.

Workers should contact the interpreting service used within the Trust in good time to ensure attendance for planned meetings/assessments.

Where appropriate, those who know the person well, including their family, carers and workers from professional or voluntary support services, may be able to advise on the best ways to communicate with the person. It may be appropriate for one of these people to be

present in the assessment and support the person (and/or help with their communication), but the worker must consider and document their thinking in relation to this, for example in terms of any potential issues of undue influence.

7.4 Concluding That the Person Lacks Mental Capacity

If the answer to any of the 4 aspects of the functional test is no, the person lacks capacity to make this particular decision it should be recorded that the person lacks capacity and the reasons why. This will be proof of the assessor's reasonable belief of incapacity at that time for that specific decision.

Note that this is legal matter. The standard of proof is the balance of probabilities and the burden of proof lies with the individual who is asserting that the person lacks capacity

If a person is assessed as not having capacity to make a particular decision it should not be assumed that they lack capacity to make other decisions.

A person's ability to understand may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication.

However, in such circumstances it must not be assumed that they do not have mental capacity to consent.

The MCA does not apply if the inability to make the decision is not because of an impairment of, or disturbance in, the functioning of, the mind or brain. In this circumstance other legal advice should be sought.

7.5 Temporary impairment of, or disturbance in, the functioning of the mind or brain.

A temporary impairment or disturbance may occur for a variety of reasons. Confusion may result for infection, such as urinary tract infection (UTI) in older people; intoxication may be a factor, or there may be temporary effects from a head injury.

If the impairment or disturbance is temporary, the lack of mental capacity may also be temporary.

If the treatment decision can wait until capacity returns, then it should be delayed until that time

If urgent treatment is required and the decision cannot wait then the person should be treated as is reasonably required in their best interests, pending the recovery of capacity. However, workers must be aware that a valid and applicable advance decision to refuse treatment is legally binding, even in urgent situations.

7.6 Fluctuating Mental Capacity

It is possible for capacity to fluctuate e.g. in the course of mental illness. In such cases it is good practice to establish, at a time when the person has capacity, what their views are about any care or treatment that may become necessary and record their views. The person may wish to make an advance decision to refuse certain types of treatment; this should be undertaken in line with sections 24-26 of the MCA

If, in the case of fluctuating capacity, a decision cannot safely be delayed, the person may be considered to lack capacity.

7.7 Recording the Capacity Assessment

The need for formal recording of a capacity assessment will depend on the nature of the decision for the particular person involved. The more serious or contentious the decision for that individual, the more stringent the record must be.

The MCA Code of Practice states that assessments of capacity to take day-to-day decisions or consent to care require no formal assessment procedures or recorded documentation, but a doctor or healthcare professional proposing treatment should carry out an assessment of the person's capacity to consent (…) and record it in the patient's clinical notes.

However, the latter may prove over burdensome.

The Trust has therefore agreed minimum standards for the recording of capacity and consent in terms of both the standard required and where the record should be made.

These are available on the intranet.

7.8 Unwise Decisions – Principle 3

Mental capacity should not be confused with a worker's assessment of the wisdom, reasonableness, or rationality of the person's decision. A person who has capacity has the right (enshrined in Article 8 of the European Convention on Human Rights) to make an autonomous decision, even if it is perceived by others to be unwise, unreasonable, or irrational.

Making a decision that others view as unwise does not necessarily mean that a person lacks capacity to make that decision. However, if the person repeatedly makes decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character, there might be a need for further investigation.

Be aware that the person might refuse consent because they do not believe the advice that they are being given. In these cases the worker must make further enquiries as to why the person does not believe that advice. The person may be refusing treatment because they have a poor relationship with the worker or do not trust them, or the person may consider that the worker is not sufficiently senior to give the advice. In such circumstances, every effort should be made to secure an appropriate person to explain the relevant information.

Care should be taken not to underestimate the capacity of a person with a learning disability or other cognitive impairment. Many people have the capacity to consent if time is spent explaining to the individual the issues in simple language, using visual aids and signing if necessary.

Further information about assessing the capacity of people generally can be found in the Mental Capacity Act 2005 Code of Practice

7.9 Question 2: Does the person consent?

In order to give valid, informed consent:

- The person must have been provided with the pertinent information (Montgomery test),
- The person must have mental capacity to decide
- The person's consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment.

Such pressure might come from partners or family members as well as health or care workers. Workers should be alert to this possibility, and where appropriate should arrange to see the person on their own to establish that the decision is truly that of the person.

When people are seen and treated in environments where involuntary detention may be an issue, such as prisons and hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the person makes a decision freely.

Coercion should be distinguished from providing the person with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for the person's health. However, threats such as withdrawal of any privileges or withdrawal of leave from the ward or using such matters to induce the person to give consent are not acceptable. Consent that has been obtained in this way will not be valid.

If a worker thinks that a person is under undue pressure it will be necessary to take action to ensure that no intervention is delivered on that basis. Possible Safeguarding or legal advice should be sought as appropriate

7.10 Who should Seek Consent?

The worker giving the treatment or carrying out the intervention is responsible for ensuring that the person has given valid consent before treatment begins and for recording it afterwards.

The task of seeking consent may be delegated to another worker, as long as that professional is suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved in order to be able to provide information about the treatment or procedure to the person and discuss the risks.

Inappropriate delegation (for example where the worker seeking consent has inadequate knowledge of the procedure) may mean that the "consent" obtained is not valid. Workers are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

7.11 When Should Consent Be Sought?

Consent should always be sought before any treatment or intervention is given. This may take the form of a simple exchange when the intervention or treatment is not of a serious nature, but in more complex situations for a particular individual, the seeking and giving of consent may be a process, rather than a one-off event.

For both major and minor interventions, it is good practice where possible to seek the person's consent to the proposed procedure well in advance, when there is time to respond to the person's questions and provide adequate information. Workers should then check, before the procedure starts that the person still consents. If a person is not asked to signify

their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity.

Individuals with capacity must be given the opportunity to consent to admission to hospital, although detention of a capacitous person under the MHA may occur in the absence of consent, subject to their meeting the necessary criteria.

7.12 Recording of Consent

A record should always be made of a person's consent or refusal if they have capacity, or - if they lack capacity - of their assent, cooperation, other means of acquiescence or objection (however expressed).

The validity of consent does not depend on the form in which it is given and it can be given in writing on a form, or given verbally, or – **IF the person HAS CAPACITY, valid consent can be implied** by the person's behaviour (such as offering an arm for blood to be taken).

NB – WHERE CAPACITY IS LACKING, assent, cooperation, or other means of acquiescence to or with an intervention of any kind (such as offering an arm for a blood test) MUST not be regarded or recorded as implied consent

Written consent serves as evidence of consent: the fact that a person has signed a consent form, however will not amount to valid consent if the person does not have capacity, has not been given adequate information or is under undue pressure or influence.

The Trust has agreed minimum standards for the recording of capacity and consent in terms of both the standard required and where the record should be made. These are available on the intranet

In all circumstances the worker should record the consent process that has been undertaken in the person's care plan/electronic record. Where the facility exists, they should (as appropriate) use the Trust's Consent and Capacity form on Insight or 'tag' information relating to consent/capacity which is recorded in the daily notes in order to make it more easily identifiable.

7.13 Duration of Consent

When a person gives valid consent to a proposed intervention, that consent remains valid for an indefinite duration leading up to the actual intervention unless it is withdrawn by the person.

However, if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken, the new information must be given to the person and their consent reviewed. Similarly, if the person's condition has changed significantly in the intervening time, it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention may also have changed.

If consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent (assuming they retain capacity) still wishes the intervention to proceed even if no new information needs to be provided or further questions answered. If it is thought that the person may have lost capacity in the intervening period then the provisions of the Mental Capacity Act (2005) must be followed.

If treatment is of an on-going nature (for example, psychological therapy), then consideration should be given to the frequency with which the issue of consent is revisited. This will vary from person to person and situation to situation. For example, for some people with learning disabilities, it may be necessary to revisit the issue at every appointment.

7.14 Reluctance to Make a Decision

Some capacitous people may wish to know very little about the treatment which is being proposed and may ask that the health professional or other person make decisions on their behalf. In such circumstances, the health professional should explain the importance of knowing about the treatment and try to encourage the person to make the decisions for themselves. However if the person still declines any information offered, it is essential to record this fact in the notes.

It is possible that people's wishes may change over time, and it is important to provide opportunities for them to express this.

7.15 Attendance by Students and Trainees

If students/trainees are observing for the purposes of their own learning, then the person must be informed that they can refuse to have the student/trainee present. It will be a clinical decision as to whether a student remains present to observe in the event that the person lacks capacity to consent to or refuse their presence.

Where a student or trainee health professional is undertaking examination or treatment of the person where the procedure will further the person's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure.

However, the person must be informed of the student/trainee's status and there is a duty to ask whether the person consents to a student undertaking a procedure, and for their consent or refusal to be recorded.

People have the right to refuse consent for the student or trainee to be present or to carry out the procedure in these circumstances without any detrimental effect on their treatment, however, clear information should be given and recorded if waiting for a qualified worker might lead to a delay in being seen and/or treated. If the person lacks capacity to decide on the involvement of a student or trainee, there should be a recorded best interests decision.

7.16 People Refusing Treatment

If an adult with capacity makes an autonomous decision to refuse treatment this decision must be respected, (except where a statutory exception applies such as the Mental Health Act 1983 - see below) and any attempt to treat that person against their wishes could amount to criminal offence/civil tort.

It is the right of an adult person with capacity to refuse treatment even if that refusal might result in their death.

Whilst a person has the right to refuse treatment there is no provision in law by which they can insist on a particular course of treatment

7.17 Withdrawal of Consent

A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the health professional, if at all possible, to stop the procedure, establish the person's concerns, and explain the consequences of not completing the procedure. If a person withdraws their consent at this point (and there is no reason to doubt their capacity to make this decision), then the procedure should stop. At times an apparent objection may reflect a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the health professional to continue with the person's consent.

7.18 Informal admission (MHA s 131)

A person can consent to informal admission for treatment of their mental disorder (ie they can consent to receive the treatment without being detained under the MHA) if they have mental capacity to do so.

The pertinent information to be discussed with a person in establishing that they consent is as follows:

1. That s/he is being admitted informally which means, subject to s5(4) or S5(2), s/he could ask the ward staff to allow them to leave the hospital whenever they want.
2. That the purpose of the admission is to treat their mental disorder.
3. That such treatment might involve the administration of medication.
4. That during their stay in the hospital s/he will be subject to hospital rules which might involve placing some restrictions on them.

This information is contained on form CAT1, which should be completed **before** admission, or in the event that the patient is discharged from detention and remains in hospital informally.

7.19 Treatment given under the Mental Health Act 1983

Treatment for mental disorder under the MHA is governed by complex rules under Part 4 and Part 4A of the MHA.

Treatment under the MHA may be administered only if is there is lawful authority to give it, and – for certain patients – the necessary certification is in place.

Lawful Authority is provided by patient consent or by applying the provisions of the MHA in respect of treatment in the absence of consent. Absence of consent can occur because the patient lacks capacity, or because s/he has capacity and refuses the treatment (there are separate provisions if the treatment in question is Electro Convulsive Therapy – ECT).

In exceptional circumstances, lawful authority may emanate from a decision made in advance under the MCA: Lasting Power of Attorney or an Advance Decision to refuse treatment.) Please see 7.20 below.

Certification is provided by the Responsible Clinician (RC) or through the involvement of a Second Opinion Appointed Doctor (SOAD), depending on the nature of the treatment and the status of the patient.

Detention under the MHA must not be seen as evidence of lack of capacity

The overlap between the MCA and the MHA is contained in Chapter 13 of the MHA Code of Practice.

See also Chapters 23 – 25 of the MHA Code of Practice in relation to treatment of mental disorder.

The Trust has an electronic form for recording capacity and consent to medication given under the MHA and for the administration of ECT (whether MHA or MCA). The form provides:

CAT1 – informal admission as described above at 7.18
CAT2 – treatment of informal patients, and detained patients in the period prior to formal certification becoming necessary after 3 months of treatment with medication
CAT3 – review of capacity and consent approaching the 3-month point
CAT4 – assessment of capacity and consent for patients on a Community Treatment Order
CAT5 – treatment with ECT

7.20 Wishes Expressed in Advance

The MCA makes provision for legally binding advance decision-making for people who have attained the age of 18 years and who have capacity to do so: the ability to appoint a person or persons to have Lasting Power of Attorney (LPA, MCA sections 9-14) and the ability to make an Advance Decision to Refuse Treatment (AD, MCA sections 24-26).

7.20.1 Lasting Power of Attorney (LPA) – legally binding

The Mental Capacity Act introduced a form of power of attorney called a Lasting Power of Attorney (LPA).

An LPA must be registered with the Office of the Public Guardian for it to be valid, and will be for the purpose of making decisions in respect of either health and welfare, or property and financial affairs (the same person can have both in place if they wish). If it is not clear that attorneys have actually been appointed, then it is necessary to check with Office of the Public Guardian. Advice can be sought from the Head of Mental Health Legislation if required.

It is essential that workers ensure:

a) that a person claiming to have LPA does in fact have a properly registered LPA, and that a note of its existence and content /scope is made in the care record. It is advised that a copy is taken and kept on the patient's electronic record so the powers it contains are available to all members of the clinical team.

b) that the LPA covers the decision in question

c) if two or more people have been appointed as attorneys, whether they are appointed to act jointly, or jointly and severally. If they are acting jointly then any decision must be by consensus; if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other

d) in the case of LPA for property and financial affairs only , that the LPA may permit the holder of the power to exercise it when the person retains capacity. Whether this is the case will depend on what the donor stipulated within the LPA. Note: the person must lack capacity for a health and welfare LPA to have effect.

Note that the person(s) in possession of LPA becomes the decision maker; s/he stands in place of the person and the Attorney's decision has the same effect as if the person has capacity and is contemporaneously making the decision. However, the person with LPA is bound by the MCA and its Code of Practice and must act in the person's best interests.

In the event that there are grounds for believing that the attorney is not making decisions that are in the best interests of the person, or are not compliant with the MCA and its Code of Practice, this should be reported as a safeguarding concern and brought to the attention of the Head of Mental Health Legislation. It may become necessary to report the concerns to the Office of the Public Guardian (OPG). The OPG may investigate and subsequently refer the case to the Court of Protection.

In the event that sexual or physical abuse, theft or serious fraud is suspected, this should be reported to the police and safeguarding measures instigated.

Note that an LPA does not authorise an attorney to refuse or give consent to life sustaining treatment unless this is specifically expressed in the instrument that creates the LPA.

7.20.2 Advance Decisions to Refuse Treatment

A person who is 18 or over and has capacity may make an Advance Decision to Refuse Treatment (AD) to take effect at a time when they no longer have capacity. Any AD that complies with the Mental Capacity Act 2005 and is valid and applicable to the treatment that is proposed, has the same effect as if that person has capacity and is contemporaneously refusing consent to treatment.

If a person has made a valid and applicable advance decision and had the right to refuse the treatment when they made the advance decision, they will have the same right when they no longer have capacity unless a statutory exception applies, see 7.18

A worker who knowingly treats a person where there is an advance decision to refuse that treatment will be acting unlawfully and liable to a claim of battery.

An AD must clearly specify the type of treatment that is being refused although this can be expressed in layperson's terms and made in the absence of professional advice. There is no requirement for an assessment of capacity at the time the advance decision is made.

With the exception of ADs refusing life-sustaining treatment, the AD does not have to be in writing, and if it is written there is no requirement for the AD to be witnessed.

A written AD may be withdrawn orally. Oral alterations to written ADs can be made, unless the alteration results in an AD refusing life sustaining treatment

Note that ADs refusing life sustaining treatment <u>are</u> required to comply with MCA s25(5) & 25(6), see below.

7.20.2.1 Applicability of AD

An AD is **<u>not applicable</u>** to the treatment in question if:

- the treatment is not specified in the AD
- any circumstances specified in the AD are absent

- there are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of the AD and which would have affected his/her decision had s/he anticipated them

An AD is not <u>applicable</u> to life sustaining treatment unless it complies with MCA s25(5) & 25(6), in that :

- the person has verified in the AD that it is to apply even if their life is at risk
- it is in writing
- it is signed by the person him/herself or by another in the person's presence and at his/her direction
- the signature is made or acknowledged by the person in the presence of a witness
- the witness signs or acknowledges his signature in the person's presence

7.20.2.2 Validity of AD

An AD is **<u>not valid</u>** if the person:

- has withdrawn it at any time when s/he has capacity to do so
- has – after the date of the AD - created an LPA conferring authority on the donee to make the specific decision in question
- has done anything else clearly inconsistent with the AD remaining his/her fixed decision that might be perceived as acting inconsistently with that decision
- there are reasonable grounds for believing that there are circumstances that had the person known about they would not have made the decision (for example there may be a medical advancement of which a person was unaware of at the time they made the advance decision)

A health professional will not be acting unlawfully if they treat a person and are genuinely unaware of the existence of an advance decision.

Conversely they will not act unlawfully if they act in accordance with an advance decision that they believe is valid and applicable at the time but is later proved to be invalid.

If there is any doubt about the validity or applicability of an advance decision and it is necessary to refer the matter to the Court of Protection, then workers may provide life sustaining treatment or treatment that prevents serious deterioration in the person's condition whilst the decision of the Court is awaited.

Further information about advance decisions to refuse treatment is available in the Mental Capacity Act Code of Practice.

7.21 Other Types of Expression of Wishes – not legally binding

A person may also express views, opinions wishes or preferences in advance that are not legally binding. These may have been expressed orally or exist in written documents. Such documents may be described in a variety of ways, for example 'Advance Statements' or 'Crisis Plans', or there may be information in a formal AD that is not valid and applicable in the circumstances but does reflect what the person's own decision might be.

Non-binding expressions of views, preferences etc may be made about a range of medical and other issues. Unlike an advance statement to <u>refuse</u> treatment, some statements will

express the person's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity.

A health professional is not under a legal obligation to provide treatment because the person demands it. The decision to treat is ultimately a matter for his or her professional judgement acting in the best interests of the person.

However, MCA s4(6)(a) requires that any such expression of past or present wishes or feelings must be considered in determining the person's best interests "in particular any relevant written statement made by him when he had capacity

Although not legally binding, these other forms of advance expression of wishes should be adhered to if at all possible, and the reasons for not adhering to such statements should be explained to the person concerned and recorded in the care record.

Note that case law in respect of the weight afforded to the person's own wishes, even when currently lacking mental capacity is evolving and should be referred to as necessary.

7.22 Adults without Capacity: Principles 4 Best Interests

7.22.1 General Principles

Where an adult lacks capacity to give his or her consent to treatment, no one can give consent for that person unless they have authority under a Lasting Power of Attorney or have been authorised to make treatment decisions as a deputy appointed by the Court. However, decisions still need to be made about the person's care and treatment.

The Mental Capacity Act sets out the circumstances in which decisions may be made on behalf of a person and makes it an offence to ill-treat or neglect them. Detailed guidance is provided in the Mental Capacity Act Code of Practice and any person engaged in the care and treatment of an adult who lacks capacity must have regard to this Code.

The Act provides that any treatment of an adult who lacks capacity will be lawful, provided that the worker reasonably believes that the person lacks capacity to make a decision in relation to the matter, and the treatment proposed is in the person's best interests.

7.22.2 Best Interests - MCA s4

In determining what is in the person's best interests, the worker must look at the person's circumstances as a whole and not just at what is in the person's best medical interests. They must try to ascertain what the person would have wanted if they had capacity, rather than what that worker believes to be in his or her best interests.

The worker must consider the person's past and present wishes and feelings, the beliefs and values that would be likely to influence the person's decision if they had capacity, and must take account of any other factors that the person might think relevant.

They must also, so far as is practicable and appropriate, take account of the views of the following people:

- Anyone named by the person as a person who should be consulted on the matters in question or on matters of that kind
- Anyone engaged in caring for the person or interested in his or her welfare;

- Any done of a Lasting Power of Attorney granted by the person; and
- Any deputy appointed for the person by the Court.

Where a person has made a Lasting Power of Attorney or a deputy of the Court has been appointed then, if it is within their authority, it will be for the attorney or deputy to make the decision on the person's behalf.

However, they too must act in the person's best interests and, where practicable and appropriate, all of the above named people must still be consulted.

Lack of capacity will not automatically mean that the person is unable to participate in the decision making process, and every assistance should be given to enable them to do so.

Where a person has made an advance statement as described above (see 7.19.2) then this will be relevant in deciding what is in the person's interests.

If it is a valid and applicable advance decision to refuse treatment (AD) made under the Mental Capacity Act (2005), then the question of what is in the person's best interests is irrelevant and the person's refusal of treatment is binding on the health professional (unless it is being given for treatment of mental disorder under Part 4 of the MHA).

However, MCA s4(6)(a) requires that any such expression of past or present wishes or feelings must be considered in determining the person's best interests "in particular any relevant written statement made by him when he had capacity".

Therefore, if the person has made an AD that is not valid and applicable or any other non-binding advance statement of wishes/preferences etc, then the health professional should still take that statement into account in deciding what is in the person's best interests.

If a person has no one close to the them to give an opinion about what is their best interests, then workers must consider whether the circumstances are such that an advocate or Independent Mental Capacity Advocate (IMCA) should be instructed.

Some decisions will need to involve an IMCA if there is no one close to the person to give an opinion about what is their best interests.

7.22.3 Independent Mental Capacity Advocates

If a person who lacks capacity is to receive serious medical treatment (as defined by Practice Directions published by the Courts and Tribunals Judiciary) or a decision to place a person in, or there is to be a decision involving moving them between longstay hospital or other long-stay accommodation, then (unless a decision has to be made urgently) an IMCA must be instructed.

The duty to instruct rests with the organisation proposing to make the decision.

A contract is in place for the provision of IMCAs.

The role of the IMCA is to represent and support the person. They will not make decisions on the person's behalf and such decisions will still be made by the relevant decision maker on the basis of what is in the person's best interests.

However the IMCA will speak to the person and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the person's best interests and the health professional must take into account the views of the IMCA in deciding what actions to take. They are entitled to information about the person and to see his or her relevant health records.

Where serious medical treatment, as defined by the relevant regulations is proposed (as defined by Practice Directions published by the Courts and Tribunals Judiciary) they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

7.22.4 Court Appointed Deputies

The Mental Capacity Act provides that the Court of Protection can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the person. Deputies will normally be family, partners, friends or people who are well known to the person.

Deputies may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the Act.

Deputies are also subject to a number of restrictions in the exercising of their powers. For example, a deputy cannot refuse consent to the carrying out or continuation of life sustaining treatment for the person, nor can they direct a person responsible for the person's healthcare to allow a different person to take over that responsibility

Workers should co-operate with deputies with the aim of doing what is best for the person. Where a deputy acting within their authority makes a decision that the person should not receive a treatment that is not life-sustaining or requires that a treatment that is not life-sustaining should be discontinued, that professional must act in accordance those instructions.

However, a deputy cannot require a health professional to give a particular type of treatment, as this is a matter for his or her clinical judgement. In such cases where a health professional has declined to give treatment, then it is good practice to seek a second opinion, although the deputy cannot insist that the health professional steps aside to allow another professional to take over the case. Deputies are supervised by the Office of the Public Guardian, and where a health professional suspects that a deputy is not acting in the interests of the person, they should raise a safeguarding concern and inform the Head of Mental Health Legislation. A referral to the Office of the Public Guardian may subsequently be needed.

7.22.5 Referral to the Court of Protection

Where there are difficult or complex decisions to make on behalf of a person who lacks capacity, the matter can be referred to the Court of Protection via the Trust's usual systems.

Workers are most likely to involve the Court of Protection where there is a dispute about a person's capacity to make a decision about a particular type of medical treatment, or whether a person had capacity when an advance decision or Lasting Power of Attorney was made. The Court can also make declarations about the lawfulness of a particular course of action

such as withdrawing or withholding medical treatment. It can make orders about a person's welfare or property and affairs. As with any other person who makes a decision on behalf of the person, the Court will act in the person's best interest.

If involvement with the Court of Protection is a possibility, please liaise with the Trust's Head of Mental Health Legislation in the first instance. Advice will be provided on due process if the Court of Protection may be necessary.

7.23 Adults without Capacity: Principle 5 – the Least Restrictive Option

7.23.1 General Principles

MCA s 1(6) requires that:

" before [an]act is done or [a] 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 restrictive of the person's rights and freedom of action"

Therefore, anyone making a decision or acting on behalf of a mentally incapacitated person must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedom of action, or whether there is a need to act at all.

However, an option that is not the least restrictive may still be found to be the option that is in the person's best interests.

Workers should note that it may be possible to make changes to the environment or to provide equipment which may serve to keep a person safe or carry out an intervention without imposing restrictions on the person him/herself .

8 Development, Consultation and Approval

This policy was originally developed by a Mental Capacity Act Steering Group (now the Mental Health Legislation Operational Group), following wide consultation with clinical teams.

It has been reviewed by the Trust's Head of Mental Health Legislation and amended version circulated to members of the Mental Health Legislation Operational Group.

Some additional elements have been added to this new version to take provide further clarification where practice issues may have arisen.

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Audit in respect of mental capacity assessments and best interest decisions, and whether they are undertaken in accordance with KPIs	SHSC Mental Capacity Assessment and Best Interests Decision Audit Tool to be completed.	Head of Mental Health Legislation; Clinical Directors; Matrons; Service Managers; Ward Managers	Monthly	Mental Health Legislation Operational Group	Head of Mental Health Legislation/Mental Health Legislation Operational	Head of Mental Health Legislation/Mental Health Legislation Operational/Mental Health Legislation Committee

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is scheduled for 3 years post approval.

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and internet and remove old version	Policy Governance	December 2022	Uploaded
Advise staff of updated policy	SHSC Comms team	December 2022	Uploaded
Ward/Team Managers to ensure that staff are aware of policy	Heads of Service, Heads of Nursing, Clinical Directors	December 2022	Uploaded

11 Dissemination, Storage and Archiving (Control)

A copy of the approved policy will be uploaded to the Trust's intranet and internet site. Its approval will be disseminated by communications Trustwide email. The Mental Health Legislation Operational Group members will be informed when approved.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
7	November 2022	November 2022	November 2022	N/A

12 Training and Other Resource Implications

No specific training is required regarding this policy. It is a pre-existing policy and is based on the law and best practice. There is also pre-existing mandatory training in relation to the Mental Capacity Act.

Some training will need to be delivered to ward/service managers on how to use the new audit tool. This will be delivered by the Head of Mental Health Legislation.

13 Links to Other Policies, Standards (Associated Documents)

Mental Capacity Act 2005
Mental Capacity Act Code of Practice
Mental Health Act 1983 (as amended)
Mental Health Act Code of Practice
All other Mental Health Act policies.

SHSC Minimum Standards for Recording Capacity and Consent

14 Contact Details

Title	***Name***	***Phone***	***Email***
Executive Medical Director	Dr Mike Hunter	271 6310	mike.hunter@shsc.nhs.uk
Head of Mental Health Legislation	Jamie Middleton	271 6210	jamie.middleton@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	No	No	N/A
Disability	Yes – inappropriate judgements may be made about a person's ability to make decisions based on a disability they may have. A person with a disability may need information provided in a different format, or given additional support, to help them make decisions for themselves.	No changes necessary as the policy and law already emphasises that judgements about decision making cannot be based on assumptions or a person's diagnosis.	N/A
Gender Reassignment	No	No	N/A

Pregnancy and Maternity	No		N/A
Race	There is a risk that inaccurate and inappropriate conclusions may be made about a person's decision-making ability based on language differences. Difficulty understanding English does not automatically mean the person lacks capacity to make decisions.	No changes necessary as the policy and law already emphasises that judgements about decision making cannot be based on assumptions or cultural difference.	N/A
Religion or Belief	No	N/A	N/A
Sex	No	N/A	N/A
Sexual Orientation	No	N/A	N/A
Marriage or Civil Partnership	No		

Please delete as appropriate: - No change made.

Impact Assessment Completed by:
Jamie Middleton, Head of Mental Health Legislation
15.11.22

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Y
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y