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This policy supersedes the following which must now be destroyed

Reference Number	Title
NTW(C)34 – V04	Mental Capacity Act Policy

Mental Capacity Act 2005

Appendices – listed separately for easy printing				
Document No:	**Description**	**Issue**	**Issue Date**	**Review date**
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Appendix 1a	Record of Best Interest Decision MCA2	1	Feb 16	Feb 19
Appendix 1b	Assessment Form checklist	1	Feb 16	Feb 19
Appendix 1c	Acid Test	1	Feb 16	Feb 19
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Practice Guidance Notes				
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MCA-PGN-01	**Assessing Capacity for Consent to Sexual Relations**	01	Feb 16	Feb 19
Appendix 1	Impact Assessment	01	Feb 16	Feb 19
MCA-PGN-02	**Advance Decision to Refuse Treatment and Advance Statements**	01	Feb 16	Feb 19
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1 Introduction

1.1 Northumberland, Tyne and Wear NHS Foundation Trust (the Trust) will implement and adhere to the Mental Capacity Act 2005 (MCA), its Code of Practice (CoP) and associated regulations and any subsequent amendments.

1.2 The MCA provides a statutory framework for decision making in respect of people who lack or may lack the mental capacity to decide for themselves. It is designed to empower and protect vulnerable people who may not be able to make their own decisions and provides a framework for people with capacity to make plans for a time in the future when they may have lost mental capacity.

1.3 The MCA makes clear how capacity assessments are to be undertaken, who can take decisions in respect of an incapacitated person, in which situations they can do this and how they should go about it. It also enables people to plan ahead for a time when they may lose capacity. It replaced statutory schemes for Enduring Powers of Attorney (EPA) and Court of Protection receivers with reformed and updated schemes.

1.4 The interpretation and operation of the MCA changes following developments in case law and it is important that this Policy should be read in conjunction with any MCA Guidance Notes and associated documentation. This will be posted on the Trust Intranet and issued to Service Managers as appropriate. The guidance notes and relevant documentation will be incorporated into the MCA Policy at review.

1.5 The MCA is accompanied by the Mental Capacity Act Code of Practice (Code of Practice), which provides further guidance on how the MCA's provisions are to be applied in practice. Trust staff are required by law to have regard to the MCA and the Code of Practice whenever they deal with a patient in circumstances where the MCA applies.

1.6 The relationship between the MCA and the Mental Health Act 1983 (MHA) is complex. However, in general terms:

- Where a patient is detained under the MHA, they can be given treatment for their mental disorder and for symptoms of that mental disorder without their consent. In these circumstances, the MCA will not apply and the provisions of Part IV of the MHA should instead be relied upon when determining whether to provide treatment;

- Where a detained patient requires treatment which is not for their mental disorder or any symptom of it (for example, treatment for a medical condition which is not related to their mental disorder), they cannot be provided with this treatment without their consent. In these circumstances Part IV of the MHA cannot be relied upon in order to give treatment without the patient's consent, and instead the provisions of the MCA will apply. Either the patient's valid consent to treatment must obtained, or a best interests decision must be properly reached where the patient is assessed as lacking capacity to give their consent;

- Where a patient is not detained under the MHA, their valid consent to treatment is required and they cannot be treated without consent under Part IV. The provisions of the MCA will apply in full in these cases.

1.7 The MCA only applies to patients aged 16 or over. Where the patient is a child:

- If the child is detained under the MHA, they can be given treatment for their mental disorder and for symptoms of that mental disorder without consent under Part IV of the MHA;

- If the child is detained under the MHA and treatment is required for a medical condition which is not related to their mental disorder, consent should be sought from a person with parental responsibility for the child, or from the child themselves if they are competent to give consent. Staff should refer to the NTW(C)05 Consent to Examination or Treatment Policy for guidance on treatment of children in this situation.

- If the child is not detained under the MHA, consent to treatment should be sought either from a person with parental responsibility for the child, or from the child themselves if they are competent to give consent. Staff should again refer to the Trust's policy on treatment of children in this situation.

1.8 Chapter 13 of the MCA Code of Practice gives further guidance on the relationship between the MCA and the MHA.

1.9 Any issues regarding the implementation and practice of the MCA should be brought to the attention of Mental Health Legislation Development Lead as and when they arise.

2 Purpose

2.1 The MCA applies in conjunction with other legislation relevant to or affecting the care, treatment or management of property and financial affairs of people who may lack capacity. This includes, but is not limited to, the Care Act 2014, Care Standards Act 2000, Data Protection Act 1998, Disability Discrimination Act 1995, Equality Act 2010, Human Rights Act 1998, Mental Health Act 1983, National Health Service and Community Care Act 1990 and Human Tissue Act 2004.

2.2 Trust staff need to be able to determine a person's mental capacity in relation to the decisions they face both throughout the adult care process and more widely in their lives. This guidance helps staff to understand the factors that affect capacity and to assess capacity and best interests where necessary.

2.3 The MCA imposes strict obligations upon health and social care staff when assessing capacity and when reaching decisions as to the best interests of incapacitated persons. It also provides legal protection to health and social care staff who fulfill these obligations and who follow the statutory procedures carefully and reasonably.

3 Key Principles

3.1 The MCA details five guiding principles which health and social care staff must have regard to at all times when dealing with a person who lacks or may lack capacity in relation to a matter:

3.1.1 The presumption of capacity

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise

3.1.2 Individuals being supported to make their own decisions

- A person must be given all practicable help to reach their own decision before anyone treats them as not being able to make that decision

3.1.3 Unwise decisions

- Just because a person makes what might seem an unwise decision, they should not be treated as lacking in capacity to make that decision

3.1.4 Best interests

- An act done or decision made under the MCA for or on behalf of a person who lacks capacity must be done or made in their best interests

3.1.5 Least restrictive option

- Anything done for or on behalf of a person who lacks capacity should interfere with that person's basic rights and freedoms as little as possible

4 Assessing Capacity

4.1 The MCA defines incapacity as follows:

> **"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"**

4.2 The MCA sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" test: that it to say, a person's capacity is only ever assessed in relation a specific decision that needs to be taken, and not in general. It is also a "time-specific" test: that is to say, their capacity is assessed to take that decision at that time, and again not in general.

4.3 Anyone assessing someone's capacity to make a decision for themselves must use the following two-stage test of capacity (Diagnostic Test):

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind works? (It does not matter whether the impairment or disturbance is permanent or temporary).

- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

The answer to question 2 will be determined by applying the four stage functional test set out below at paragraph 5.3.

4.4 The outcome of any assessment of a person's capacity must be clearly recorded in their health records. Staff should also refer to the Trust's policy, NTW(C)05 Consent to Examination or Treatment.

4.5 No one can simply be labelled 'incapable' as a result of a particular medical condition or diagnosis. Instead a person must always be assessed properly applying the MCA capacity test set out in this document, and an objective view must be taken as to whether they have the capacity or not to take the decision in question.

4.6 A lack of capacity cannot be established merely by reference to:

- A person's age or appearance, or
- A condition, or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity

4.7 Any question as to whether a person lacks capacity must be decided on the balance of probabilities.

5 Assessing ability to make decisions

5.1 The second part of the capacity test involves assessing whether a person who is suffering from some sort of mental impairment or disturbance is consequently unable to make the decision in question at the time it needs to be made. A person's ability to make a decision is assessed by applying the four stage functional test set out below.

5.2 Before a person is asked to reach a particular decision, they must be given all of the relevant information they need to make a fully informed decision.

5.3 The person will be unable to make a decision for themselves if they are unable to do any one of the following four things:

- Understand the information relevant to the decision, or
- Retain that information, or
- Use or weigh that information as part of the process of making the decision, or
- Communicate their decision (whether by talking, using sign language or any other means).

5.4 A person is not to be regarded as unable to understand the information relevant to a decision if they are able to understand an explanation of it given to them in a way that is appropriate to their circumstances (for example, by using simple language, visual aids or any other means).

5.5 The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision. Capacity may be established where a person is able to understand and retain information long enough to make an informed decision.

5.6 The information relevant to a decision includes information about the reasonably foreseeable consequences of:

- Deciding one way or another, and
- Failing to make the decision.

5.7 There are several further factors which must be taken into account when assessing capacity:

5.7.1 **Fluctuating / temporary capacity**

A person's mental capacity can fluctuate or be temporarily impaired due to mood or depression or an underlying physical disorder e.g. urinary tract infection. When assessing capacity, a view should also be taken as to whether the person might regain capacity in the future, and if so, when this is likely to be. If the decision can be postponed until the person regains capacity, it should be postponed, to allow the person to reach their own decision at that later time.

5.7.2 **Specific decision**

A person may have the capacity to make some decisions but not others. A person's capacity should be assessed in the context of the specific decision that needs to be made. For example, a person might have the necessary mental capacity to decide what to wear or what to eat, but might lack the capacity to take more serious decisions regarding where to live or what medical care they should receive.

5.7.3 **Information**.

Any information relevant to the decision should be provided in a format that the person is best able to understand.

5.7.4 **Pressure**

Carers or other family members may sometimes exert pressure on Trust staff to treat a patient as lacking capacity to take certain decisions and to care for them as the family would wish. Trust staff must not be influenced by such pressure, but must instead reach their own view as to the patient's capacity by applying the principles set out in the MCA, the Code of Practice and this document. However, the carers' and family members' views will be relevant when considering what might be in the best interests of an incapacitated patient. This is dealt with in more detail below at paragraph 7.

5.7.5 **A lack of trust**

- A person may feel anxious about dealing with staff from social services or any other interested agency. If so they should have access to independent support, advice or advocacy in these circumstances.

5.8 Staff should routinely try to ascertain the existence (or not) of any Lasting Power of Attorney, advance decision or advance statement at initial assessments and reviews. Changes should be documented in the person's records.

5.9 The Code of Practice provides guidance on this issue in Chapter 4.

6 Decision maker

6.1 Where a person is assessed as lacking the capacity to make a particular decision, the MCA stipulates that whatever act is done or decision is made on behalf of that person must be done or made in the person's best interests. The person who decides what would be in the person's best interests is referred to in the Code of Practice as the "decision-maker".

6.2 The decision-maker in any given case will be the person who is proposing taking action in connection with the care or treatment of an adult who lacks capacity, or who is contemplating making a decision on their behalf. The identity of the decision maker will depend upon the nature of the proposed action and the context in which it is proposed:

- Where the decision relates to medical treatment, the doctor proposing the treatment will be the decision maker;
- If the person has a care manager or care co-ordinator, they will generally be the decision maker on general issues of welfare and finance;
- Where nursing care is provided and a decision about nursing care needs to be reached, the nurse will be the decision-maker;
- For most other day-to-day actions or decisions, the decision-maker will be the person directly involved with the person at the time.

6.3 Outside hospital, the decision maker is likely to be a care worker or a family member concerning day to day actions.

6.4 The Code of Practice provides guidance on this issue in Chapter 5.

7 Best interests

7.1 The MCA provides a checklist of factors that a decision-maker must work through in deciding what is in an incapacitated person's best interests. This is referred to as the "Best Interests Checklist". All of the factors in the Best Interests Checklist must be taken into account by the decision-maker when reaching a decision as to best interests. In addition, the decision-maker must take into account any other factors that are relevant in the circumstances.

7.2 In determining for the purposes of the MCA what is in a person's best interests, the decision-maker must not make their determination merely on the basis of:

- The person's age or appearance, or
- Any condition affecting them, or any aspect of their behaviour, which might lead others to make unjustified assumptions about what might be in their best interests.

7.3 The decision-maker must consider all the relevant circumstances and, in particular, must take the steps set out below.

7.4 The decision-maker must consider whether it is likely that the person will at some time have capacity in relation to the matter in question. If it appears likely that the person will do so, the decision-maker must go on to consider when that is likely to be.

7.5 The decision-maker must, so far as is reasonably practicable, permit and encourage the person to participate, or to improve his/her ability to participate, as fully as possible in the decision itself and in any action subsequently taken.

7.6 The decision-maker must consider so far as may be reasonably ascertainable:

- The person's past and present wishes and feelings, and in particular any relevant written statement made by them when they had capacity. This will include any advance statement that the person may have made. Advance statements are dealt with in more detail below at paragraph 16; and
- Any beliefs and values of the person that would be likely to influence their decision if they had capacity, and
- Any other factors that they would be likely to consider if they were able to do so.

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

- Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind
- Anyone engaged in caring for the person or interested in his/her welfare (this will include family members and carers)
- Any donee of a lasting power of attorney granted by the person, and/or
- Any deputy appointed for the person by the court.

7.8 A best interest's decision needs to be taken in every case where a course of action is proposed for a person who lacks the capacity to consent to that course of action. This includes all aspects of the care and treatment of such a person.

7.9 However, not all best interests' decisions need to be formally recorded. In general terms, best interest's decisions concerning matters of day to day personal care and normal activities of daily living for an incapacitated person will not normally need to be formally recorded. Examples might include choosing what clothes the person should wear on a cold day, or deciding what the person should eat for lunch.

7.10 All other more significant best interests decisions must be fully recorded using an appropriate form.

7.11 It is recognised that services, specialities and systems of integrated working across the trust may mean that specific forms for assessing capacity and recording best interests may differ depending upon the needs of the service user group. For this reason there is a suggested format for recording capacity assessments and best interests shown in Appendix 1 and Appendix 1a. Both Appendix 1 and 1a can be completed within the patient's electronic record (RiO) and are located within the Mental Capacity Folder, titled Mental Capacity Assessment and Best Interests Decision. However, services are permitted to utilise assessment and recording tools relevant to their services as long as they meet the basic requirements shown in Appendix 1b. All assessments which necessitate the use of a form should be recorded on the trust's RIO system.

7.12 The following are some examples of best interest's decisions that must always be formally recorded:

- All decisions as to the care and treatment (beyond matters of day to day personal care and normal activities of daily living) of a mentally incapacitated patients whose care is authorised under Deprivation of Liberty Safeguard (DoLS)
- Medical treatment for a detained patient where the proposed treatment is not for their mental disorder or any symptom of their mental disorder. The medical treatment therefore being provided under MCA
- Care planning and mental health treatment decisions for patients whose care is authorised under DoLS
- Decisions as to ongoing care which will be subject to future review
- Decisions which may involve restricting the liberty of patients deprived of their liberty, such as those around high level observations
- Issues of dispute with family members or other interested parties
- Changes of accommodation for patient's whose care has been authorised under DoLS or on discharge from detention

NB. It is important to note decisions can only be made in Best Interest for incapacitated patients whose care will be authorised by the MHA/DoLS/MCA. Ch 13 MHA CoP provides a summary as to the availability of the MHA and of DoLS which is defined in the figure below:-

Figure 5: MHA CoP

	Individual **objects** to the proposed accommodation in a hospital for care and/ or treatment; or to any of the treatment they will receive there for mental disorder	Individual **does not object** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. Informal admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. DoLS authorisation is available, or potentially a Court of Protection order

7.13 The form should be completed each time a new best interests decision is required. This will include each time there is a change in the proposed treatment regime or care plan for a mentally incapacitated patient deprived of their liberty. Unless there are major changes in capacity or proposed interventions only one form should be completed per admission with minor changes being recorded in routine clinical notes.

7.14 Sometimes there might be disagreement or dispute as to what would be in the best interests of an incapacitated person, for example between clinicians and family members. In the event of a dispute, staff should seek local resolution if at all possible. The following may assist the decision maker to resolve the dispute:

- Involve an advocate who is independent of all parties involved
- Get a second opinion as to capacity and/or best interests
- Hold a strategy meeting of all involved
- Consider mediation

7.15 Where local resolution of a dispute is not possible despite all efforts of the decision-maker, consider with line management whether a legal perspective should be obtained. Physical attendance of a lawyer at strategy meetings should be a last resort and only after agreement of senior managers. The Court of Protection has jurisdiction to resolve disputes as to the capacity and/or best interests of an incapacitated person, and an application to the Court might be necessary in some cases. Advice can be sought from the Trust Mental Health Legislation Development Lead.

7.15 The Code of Practice provides guidance on this issue in Chapter 5.

8 Legal Protection for action done in best interests

8.1 The MCA gives legal protection to health and social care staff who take action in connection with the care or treatment of a person who lacks capacity. A staff member will have legal protection under the MCA where they:

- have taken reasonable steps (applying the principles of the MCA and the Code of Practice) to establish whether the person has capacity in relation to the matter in question, and

- when carrying out the action, the staff member reasonably believes the person lacks capacity in relation to the matter, and that it will be their best interests for the act to be done.

8.2 However there are certain limitations on the legal protection that the MCA provides. In particular:

- **Restraint.** Actions which involve restraint of a person who lacks capacity will only be justifiable under the MCA where certain further conditions are satisfied. These are dealt with in section 9 below;

- **Deprivation of liberty.** The MCA does not allow staff to deprive a person who lacks capacity of their liberty. This is also dealt with in section 9 below;

- **LPAs.** Where an attorney has been appointed under a Lasting Power of Attorney to take health and welfare decisions, staff must not act contrary to a decision made by that attorney, as long as the attorney is acting within the scope of his/her authority. Lasting Powers of Attorney are dealt with in section 11 below;

- **Deputies.** Where the court has appointed a deputy to take health and welfare decisions, staff must not act contrary to a decision made by that deputy, as long as the deputy is acting within the scope of his/her authority. Court-appointed deputies are dealt with in section 13 below;
- **Advance decisions.** Where a person has made a valid and applicable advance decision, staff must not act contrary to that advance decision, even if they believe it would be in the incapacitated person's best interests to do so. Advance decisions are dealt with in section 14 below.

8.3 The Code of Practice provides guidance on this issue in Chapter 6.

9 Restraint/Deprivation of Liberty

9.1 Section 6 of the MCA defines restraint as:

- the use or threat of force to make an incapacitated person do something that they are resisting, or
- any restriction of an incapacitated person's freedom of movement, whether or not the person resists.

9.2 Restraint of an incapacitated person is only permitted under the MCA if:

- the person using it reasonably believes that the restraint is **necessary** to **prevent harm** to the incapacitated person, and

- the amount or type of restraint used, and the duration of that restraint, is proportionate to the likelihood and seriousness of the harm.

9.3 Restraint of an incapacitated person will only be justifiable if these 2 conditions are satisfied, regardless of whether staff believe that restraint would be in the best interests of an incapacitated person

9.4 The MCA does not provide any protection for an act which deprives an incapacitated person of his or her liberty. "Deprivation of liberty" is undefined in the MCA, but in general terms an incapacitated person will be deprived of their liberty where action is taken that amounts to more than mere restraint under the definition above.

9.5. Provisions concerning deprivation of liberty of persons who lack capacity were introduced in April 2009. Staff should refer to NTW(C)36 - Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards.

9.6 Further advice and guidance should be sought from the Mental Health Legislation Development Lead.

9.7 The MCA Code of Practice provides guidance on this issue in Chapter 6.

10 Payment for goods and services

10.1 If a person lacks capacity to arrange for payment for necessary goods and services, the MCA allows a carer to arrange payment on their behalf.

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

10.3 The carer must first take reasonable steps to check whether a person can arrange for payment themselves, or has the capacity to consent to the carer doing it for them. If the person lacks the capacity to consent or pay themselves, the carer must decide what goods or services would be necessary for the person and in their best interests.

10.4 The carer can then lawfully deal with payment for those goods and services in one of three ways:

- If neither the carer nor the person who lacks capacity can produce the necessary funds, the carer may promise that the person who lacks capacity will pay. However the carer may not be comfortable with this, and equally the supplier may not be willing to accept this arrangement;

- If the person who lacks capacity has cash, the carer may use that money to pay for goods or services (for example, to pay the milkman or the hairdresser).

- The carer may choose to pay for the goods or services with their own money. If so, the person who lacks capacity must pay them back. This may involve using cash in the person's possession or running up an IOU. Someone with legal authority to handle the person's financial affairs may need to be approached to obtain reimbursement

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

10.6 The Act does not give a carer or care worker access to a person's income or assets. Nor does it allow them to sell the person's property. Anyone wanting access to money in a person's bank or building society will need formal legal authority (e.g. a Lasting Power of Attorney or Court Order).

10.7 Sometimes another person will already have legal control of the finances and property of a person who lacks capacity to manage their own affairs. This could be an attorney acting under a registered Enduring Power of Attorney or an appropriate Lasting Power of Attorney, or a deputy appointed by the Court of Protection. Alternatively it could be someone that has the right to act as an 'appointee' (under Social Security Regulations) and claim benefits for a person who lacks capacity to make their own claim and use the money on the person's behalf. The MCA makes clear that a carer cannot make arrangements for goods or services to be supplied to a person who lacks capacity if this conflicts with a decision made by someone who has formal powers over the person's money and property, such as an attorney or deputy acting within the scope of their authority.

10.8 The MCA Code of Practice provides guidance on this issue in Chapter 6.

11 Lasting Powers of Attorney (LPA)

11.1 The MCA allows a person who is aged 18 or over and who has mental capacity to appoint an attorney to take certain decisions on their behalf if they should lose capacity in the future. The MCA introduces two forms of LPA:

- Property and affairs LPAs replaced Enduring Powers of Attorney in the area of property and financial affairs;
- Personal welfare LPAs are new under the MCA and allow a person aged 18 or over to confer upon another person the authority to make decisions concerning personal welfare matters (including medical treatment and social care) if the person granting the authority should lose capacity in the future.

11.2 Where a person is acting as an attorney under a personal welfare LPA, they will be entitled to take decisions regarding the health and social care of the incapacitated person that appointed them; as long as they act within the scope of the authority they have been given. Health and social care staff will be required to go along with the decisions the attorney takes.

11.3 However, a personal welfare attorney will only be able to take decisions regarding life sustaining treatment where they have been granted the specific authority to do so by the incapacitated person in the LPA document.

11.4 An attorney cannot refuse their consent to treatment given to a detained patient under Part IV of the MHA.

11.5 All attorneys are under a duty to have regard to the Code of Practice and to act in accordance with the incapacitated person's best interests.

11.6 All LPAs must be registered with the Office of the Public Guardian when they are created. An LPA has no effect unless it has been registered in this way. When dealing with a person who claims to be the valid attorney of an incapacitated person under an LPA, Trust staff should ask to see a copy of the LPA which has been stamped on every page by the Office of the Public Guardian to confirm that it has been registered. Staff should also check the stamped LPA to confirm the

nature and extent of the attorney's authority to take decisions. An example of a stamped LPA can be found at Appendix 3b.

11.7 Further guidance is provided at Appendix 3. Make and register your lasting power of attorney a guide. The Code of Practice provides guidance on this issue in Chapter 7.

12 Court of Protection / Public Guardian

12.1 The MCA provides two public bodies to support the statutory framework, both of which are designed around the needs of those who lack capacity:

12.1.1 The new Court of Protection

- Prior to the MCA coming into force, the Court of Protection had limited jurisdiction over the property and financial affairs of incapacitated people. The MCA expanded the role of the Court of Protection, and the new Court now has jurisdiction over all matters relating to decision-making affecting adults who lack capacity, including health and social care decisions. The Court of Protection is now the final arbiter in matters of mental capacity and best interests. It has its own procedures and nominated judges.

12.1.2 Public Guardian

- The Office of the Public Guardian and its staff are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

12.2 Further guidance is provided at Appendix 4. The MCA Code of Practice provides guidance on these issues in Chapter 8.

12.3 Further information may be found at the Office of Public Guardian: https://www.gov.uk/government/organisations/office-of-the-public-guardian

13 Court – appointed deputies

13.1 The MCA provides for a system of court-appointed deputies to replace the current system of receivership in the Court of Protection. Deputies are able to take decisions on welfare, healthcare and/or property or financial matters as authorised by the Court. A deputy will only be appointed if the Court cannot make a one-off decision to resolve the issues.

13.2 A deputy may be appointed by the court to take decisions concerning the personal welfare of an incapacitated person. This might include decisions regarding the health or social care the incapacitated person is to receive. Health and social care staff will be required to go along with the decisions a deputy

takes, as long as the deputy acts within the scope of the authority he/she has been given by the court.

13.3 However a deputy does not have the power in any circumstances to refuse consent to life-sustaining treatment for an incapacitated person.

13.4 A deputy also cannot refuse consent to treatment given to a detained patient under Part IV of the MHA.

13.5 Deputies are under a duty to have regard to the Code of Practice and to act in accordance with the incapacitated person's best interests.

13.6 When dealing with a person who claims to be the court-appointed deputy of an incapacitated person, Trust staff should ask to see a copy of the sealed court order which gives the deputy their authority. Staff should also check the order to confirm the nature and extent of the attorney's authority to take decisions. All deputies are provided by the Court of Protection with extra copies of the order to demonstrate their authority when required.

13.7 The Code of Practice provides guidance on this issue in Chapter 8.

14 Advance Decisions to Refuse Treatment

14.1 Before the MCA came into force, a person with capacity could make an "advance directive" to refuse certain specified medical treatment if he/she should lose mental capacity in the future.

14.2 The MCA updates and reforms the law with regard to such statements. Under the MCA these are know known as "advance decisions". The MCA sets out clear statutory rules and safeguards confirming the procedure by which a person may make a decision in advance to refuse treatment if they should lose capacity in the future.

14.3 An advance decision can only be made by a person who is aged 18 or over at a time when that person has the necessary mental capacity to make it.

14.4 The advance decision must specify the treatment that is being refused and the circumstances in which it is being refused.

14.5 An advance decision does not need to be in writing unless it applies to life-sustaining treatment. There are specific rules about the way in which an advance decision to refuse life sustaining treatment must be made and these are set out below. An advance decision which does not relate to life sustaining treatment may be made orally or in writing and there is no specific statutory form that must be used to make an advance decision of any kind.

14.6 If the advance decision concerns life-sustaining treatment it must follow a particular format set out in the MCA. An advance decision to refuse life sustaining treatment must be:

- Made in writing

- Signed by the person making it

- Witnessed by a third party as having been validly signed by the person making it

- Accompanied by a separate statement that the advance decision is to apply even if life is at risk

- That separate statement must also be signed by the person making the advance decision, and their signature must again be witnessed by a third party

14.7 In general, an advance decision may be withdrawn or altered by the person who made it at any time by any means. However, in the case of an advance decision to refuse life-sustaining treatment, any withdrawal or alteration must be made in writing.

14.8 In order to be legally binding, an advance decision must be both:

- Valid, and
- Applicable

14.8.1 Health and social care staff must abide by an advance decision that is both valid and applicable, unless treatment is to be given under Part IV of the MHA. This is dealt with in more detail below.

14.9 An advance decision will be valid where it has been made in the correct form and where there is no reason to doubt that it reflects the genuine wishes of the incapacitated person at the time they had capacity in relation to the matter. There may be reason to doubt the validity of an advance decision where:

- There is evidence that it was revoked by the incapacitated person whilst they still had capacity, or

- There is evidence that the incapacitated person changed their mind about the matter whilst they still had capacity, or

- There is evidence that the incapacitated person made the advance decision under duress or coercion, or

- Since making the advance decision the incapacitated person appointed an attorney under an LPA with authority to take decisions in relation to the same matter

14.10 An advance decision will be applicable where:

- It sets out clearly the treatment that is being refused and the circumstances in which it is to be refused, and

- The treatment proposed is the same treatment set out in the advance decision, and the circumstances are the same as in the advance decision

14.11 Where a detained patient requires treatment for their mental disorder or a symptom of that disorder, they can be given that treatment without their consent under Part IV MHA. In these circumstances, staff can give treatment even if the patient has made an advance decision to refuse that treatment and that advance decision would otherwise be valid and applicable.

14.12 Wherever possible an oral advance decision should be recorded in a person's care record. If there is any doubt or dispute about the existence, validity or applicability of an advance decision then it should be referred to the Court of Protection for determination.

14.13 There are agreed documents which can be used for advance decisions and advance statements which are detailed in the Trust Advance Decisions Policy.

14.14 The MCA Code of Practice provides guidance on this issue in Chapter 9. Further advice and guidance can be sought from the Mental Health Legislation Development Lead.

15 Excluded decisions

15.1 The MCA covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. However there are certain decisions which can never be made on behalf of a person who lacks capacity to make those specific decisions. This is because they are either so personal to the individual concerned, or governed by other legislation.

15.2 The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity. No best interest's decision can be taken in respect of these matters. There will be no question of an attorney consenting to these decisions, or of the Court of Protection making an order or appointing a deputy to provide the requisite consent.

15.3 These decisions may be summarised as follows:

15.3.1 Decisions concerning family relationships

- Consent to marriage or a civil partnership
- Consent to have sexual relations
- Consent to a decree of divorce on the basis of two years' separation
- Consent to the dissolution of a civil partnership
- Consent to a child being placed for adoption or the making of an adoption order

- Discharging parental responsibility for a child in matters not relating to the child's property
- Consent under the Human Fertilisation and Embryology Act 1990.

15.3.2 **Voting rights**

- Nothing in the Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person who lacks capacity to vote.

15.3.3 **Unlawful killing or assisted suicide**

- Nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

15.4 Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves (for example, consenting to have sexual relations), this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

15.5 The MCA also does not apply where treatment is to be given to a detained patient under Part IV MHA. This is dealt with in more detail at paragraph 1.6.

16 Advance Statements

16.1 An advance statement is a document which is completed by a patient, at a time when they have the necessary mental capacity, to make known their wishes regarding care, treatment and other personal matters should they become unwell.

16.2 Unlike an advance decision, an advance statement will not set out to specify which types of care or treatment the person does not want to receive if they should lose capacity in the future. If a person wishes to stipulate which types of treatment they should not be given when they lack capacity, they should be advised to make a valid and applicable advance decision, bearing in mind the relevant provisions of the MCA and the formal requirements discussed in paragraph 14 above.

16.3 The purpose of an advance statement is to:

- set out the person's wishes and preferences in terms of medical treatment and relapse management;
- identify those trusted relatives, carers and/or advocates who may be contacted in an emergency or consulted with by health professionals;
- indicate what practical arrangements the individual may wish to have addressed if admitted to hospital, e.g. regarding care of dependents, safeguarding their home and managing their possessions.

16.4 Unlike an advance decision, an advance statement will not be legally binding upon health or social care professionals. However, the MCA states that when

reaching a best interests decision concerning a person who lacks capacity, a decision maker must have regard to any relevant written statements made by that person at a time when they had capacity. Decision makers will therefore be under a duty to consider the content of an advance statement when reaching a best interests decision.

16.5 An advance statement is a document that a person can write themselves, with help from their care co-ordinator or any other person. It can be written as part of a care co-ordination review, or at any other time. The Trust has a standard form for advance statements that makes them easy to do and this can be found in NTW(C)12 - Advance Decision to Refuse Treatment and Advance Statements for Mental Health. However, advance statements can be written in any format.

17 Research

17.1 The MCA sets out a new legislative framework to cover situations where "intrusive" research is to be carried out on or in relation to a person who lacks capacity. "Intrusive" research is any research which would ordinarily require a person's consent to be undertaken lawfully. However it does not include clinical trials, which continue to be covered by the Medicines for Human Use (Clinical Trials) Regulations 2004.

17.2 Research covered by the MCA cannot include people who lack capacity to consent to the research unless it has the approval of the "appropriate body". This will be the relevant Research Ethic Committee ("REC"). Approval will only be granted where certain conditions set out in the MCA are satisfied.

17.3 Research covered by the MCA must also follow the requirements of the MCA to:

- Consult with and consider the view of carers and others as to an incapacitated person's involvement in the research project;
- Treat that person's interests as paramount;
- Respect any objections of the person during the research.

17.4 The research provisions of the MCA are complex and cannot easily be summarised here. If staff should have any queries regarding research projects involving people who lack capacity, these queries should be referred to the Associate Director for Research and Clinical Effectiveness in the first instance.

17.5 The Code of Practice provides guidance on this issue in Chapter 11.

18 Independent Mental Capacity Advocates (IMCAs)

18.1 The IMCA provides additional representation and support to incapacitated persons in certain clearly defined circumstances.

18.2 The MCA places a duty upon decision-makers to consult with those close to an incapacitated person when deciding what course of action might be in that person's best interests. However, some incapacitated people may not have anyone close to them (e.g. no close family or friends) with whom a decision-maker might consult when deciding upon best interests. The role of an IMCA is to provide support and representation to an incapacitated person who has no one else close to them to provide such support, in certain circumstances where a best interest-decision needs to be taken. The decision-maker will be under a duty to involve and consult with the IMCA when deciding upon best interests.

18.3 Health and social care staff are under a duty to instruct an IMCA to represent and support an incapacitated person in the following circumstances:

18.3.1 **Serious medical treatment**

- Where an NHS body is proposing to provide, or secure the provision of, "serious medical treatment" for an incapacitated person, and where that NHS body is satisfied that there is no one other than a paid carer with whom it would be appropriate to consult in determining what would be in the person's best interests, an IMCA must be instructed to represent the patient
- "Serious medical treatment" is defined as treatment which involves providing, withdrawing or withholding treatment in circumstances where:
  - There is a fine balance between the benefits and burdens/risks to the patient, or
  - Where there is a choice of treatments, the decision as to which one is finely balanced, or
  - What is proposed would be likely to involve serious consequences for the patient.
- However there will be no duty to instruct an IMCA where serious medical treatment is provided under Part IV of the Mental Health Act 1983

18.3.2 **Long term accommodation by the NHS**

- Where a NHS body proposes to accommodate an incapacitated person in a hospital where the patient meets the acid test and is deprived of their liberty legal authority must be obtained for the deprivation. This can be through the MHA, DoLS or an order from the Court of Protection. The most appropriate legislation must be used which best meets the patient's individual circumstances. If appropriate an IMCA will be instructed in line with legal process. Staff should refer to NTW(C)36 Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards
- However there will be no duty to instruct an IMCA where accommodation is provided under Part IV of the Mental Health Act 1983

18.3.3 **Long term accommodation by a local authority**

- Where a local authority proposes to accommodate an incapacitated person in a care home (or move them to another care home) where the patient meets the acid test and is deprived of their liberty legal authority must be obtained for the deprivation. This can be through the DoLS or an order from the Court of Protection. If appropriate an IMCA will be instructed in line with legal process. Staff should refer to NTW(C)36 Deprivation of Liberty Safeguards Policy for information and systems surrounding these safeguards
- However there will be no duty to instruct an IMCA where accommodation is provided under Part IV of the Mental Health Act 1983.

18.4 An IMCA **may** also be instructed in:

- a care review regarding an incapacitated person, or
- an adult protection case that involves a vulnerable incapacitated person. Where the decision-maker is satisfied that having an IMCA will be of particular benefit to the person who lacks capacity

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

- must confirm that the person instructing them has the authority to do so
- should interview or meet in private the person who lacks capacity, if possible
- must act in accordance with the principles of the MCA and the Code of Practice
- may examine any relevant records that the MCA allows them access to
- should get the views of professionals and paid workers providing care or treatment for the person who lacks capacity
- should get the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks capacity
- should get hold of any other information they think will be necessary
- must find out what support a person who lacks capacity has had to help them make the specific decision
- must try to find out what the person's wishes and feelings, beliefs and values would be likely to be if the person had capacity
- should find out what alternative options there are
- should consider whether getting another medical opinion would help the person who lacks capacity, and

- must write a report on their findings for the local authority or NHS body that instructed them

18.6 The IMCA can challenge the decision-maker on behalf of the person lacking capacity if he/she does not agree with the decision that is ultimately reached.

18.7 Further Guidance regarding the role of the IMCA is provided at Appendix 5. The Code of Practice provides guidance on this issue in Chapter 10.

18.8 Referral to IMCA services can be done using the referral forms available on the following link IMCA Referral Forms

19 Criminal Offences

19.1 The MCA introduces 2 new criminal offences. These are:

- ill treatment of a person who lacks capacity; and
- wilful neglect of a person who lacks capacity

19.2 These offences may be committed by:

- anyone responsible for an incapacitated person's care: this could include family carers, health and social care staff in hospitals or care homes and those providing care in the person's home;
- any donee of a Lasting Power of Attorney or an Enduring Power of Attorney;
- any deputy appointed by the Court

19.3 A person found guilty of such an offence may be liable to a fine, imprisonment for a term of up to five years, or both.

20 Identification of Stakeholders

20.1 This is an existing policy under review which was circulated for a short consultation to the following:

- North Locality Care Group
- Central Locality Care Group
- South Locality Care Group
- Corporate Decision Team
- Business Delivery Group
- Safer Care Group
- Communications, Finance, IM&T
- Commissioning and Quality Assurance
- Workforce and Organisational Development
- NTW Solutions

- Local Negotiating Committee
- Medical Directorate
- Staff Side
- Internal Audit

21 Equality and Diversity Assessment

21.1 In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

22 Training

22.1 Training for the use of this policy and issues relating to the MCA will be delivered as part of the trust's mandatory training programme and will include;

- an overview of the main concepts of the act
- the principles underpinning the Act
- the assessment of mental capacity
- the concept of 'best interests' and how this is determined
- planning ahead for loss of capacity
- the role of the Independent Mental Capacity Advocate

22.2 MCA Detailed Training

22.2.1 This will provide a greater understanding of the MCA's implementation and implications for practitioners, update on operational requirements and provide some opportunity to apply and problem solve specific service issues. This will be delivered individually within teams. Advice should be sought from the Mental Health Legislation Development Lead.

22.2.2 Training records will be kept centrally by training and development.

22.3.2 Details on training can be accessed on the Trust intranet.

23 Monitoring compliance – Appendix C

23.1 Monitoring and compliance will be undertaken in accordance with the Policy Monitoring Tool, Appendix C.

24 Implementation

24.1 Taking into consideration all the implications associated with this policy, it is considered that a target date of February 2016 is achievable for the contents to be embedded within the organisation.

24.2 This will be monitored by the Mental Health Legislation Committee during the review process. If at any stage there is an indication that the target date cannot be met, then the Mental Health Legislation Committee will consider the implementation of an action plan.

25 Fair Blame

25.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

26 Fraud, Bribery and Corruption

26.1 In accordance with the Fraud, Bribery and Corruption Policy – NTW(O)23, all suspected cases of fraud and corruption should be reported immediately to the Trust's Local Counter Fraud Specialist or to the Executive Director of Finance.

27 Associated Documentation

- NTW(C)05 - Consent to Examination and Treatment
- NTW(C)20 - Care Co-ordination / CPA Policy
- NTW(C)34 – Mental Capacity Act Policy
    - MCA-PGN-02 – Advance Decision to Refuse Treatment and Advance Statements
- NTW(C)36 - Deprivation of Liberty Safeguards Policy
- NTW(C)55 - Mental Health Act Policy

28 References

- Mental Capacity Act 2005
- Mental Capacity Act 2005 Code of Practice
- The MCA and the MCA Code of Practice may be accessed from the Department of Constitutional Affairs Website http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityact2005/index.htm
- Adult Protection care reviews and Independent Mental Capacity Advocates (IMCA): Guidance on interpreting the regulations extending the IMCA role. See DH website www.dh.gov.uk/PublicationsAndStatistics and/or www.dh.gov.uk/iMCA
- Leaflets and booklets, including those in other languages can be accessed via' http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix A

Equality Analysis Screening Toolkit			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Locality**
Kerry Graham	Nov 16	Jan 2019	
Policy to be analysed		**Is this policy new or existing?**	
NTW(C)34 – Mental Capacity Act Policy – V04		Existing	

What are the intended outcomes of this work? Include outline of objectives and function aims

The MCA provides a statutory framework for decision making in respect of people who lack or may lack the mental capacity to decide for themselves. It is designed to empower and protect vulnerable people who may not be able to make their own decisions **and** provides a framework for people with capacity to make plans for a time in the future when they may have lost mental capacity. The Act came fully into force on 1st October 2007.

The MCA sets in statute previous best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It also adds a number of extra provisions to update, reform and expand upon the old law. The MCA makes clear how capacity assessments are to be undertaken, who can take decisions in respect of an incapacitated person, in which situations they can do this and how they should go about it. It also enables people to plan ahead for a time when they may lose capacity. It replaces current statutory schemes for Enduring Powers of Attorney (EPA) and Court of Protection receivers with reformed and updated schemes. This means there can be no new EPA's after October 1st 2007 but existing ones will continue to be valid.
Associated Documentation:

- NTW(C)05 - Consent to Examination and Treatment
- NTW(C)20 - Care Co-ordination / CPA Policy
- NTW(C)34 – Mental Capacity Act Policy
    - MCA-PGN-02 – Advance Decision to Refuse Treatment and Advance Statements
- NTW(C)36 - Deprivation of Liberty Safeguards Policy
- NTW(C)55 - Mental Health Act Policy

Who will be affected? e.g. staff, service users, carers, wider public etc

Protected Characteristics under the Equality Act 2010. The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them

Disability	
Sex	
Race	
Age	
Gender reassignment (including transgender)	
Sexual orientation.	
Religion or belief	
Marriage and Civil Partnership	
Pregnancy and maternity	

Carers	
Other identified groups	

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Through standard policy process

How have you engaged stakeholders in testing the policy or programme proposals?

Through standard policy process

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Appropriate policy review author/team

Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

- Policy does not unlawfully discriminate against equality target groups
- Policy promotes equality of opportunity for equality target groups

Act may highlight individual cases of discrimination, it is recommended that a review of any of these cases is undertaken after the first year of the implementation to the policy to establish whether any amendments/protocols are required. Impact Assessment should be part of the policy review process thereafter.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic

Eliminate discrimination, harassment and victimisation	
Advance equality of opportunity	
Promote good relations between groups	Potentially Positive for all groups
What is the overall impact?	
Addressing the impact on equalities	

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager's signature: Kerry Graham Date: Nov 2015

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix B

Communication and Training Check list for policies

Key Questions for the accountable committees designing, reviewing or agreeing a new Trust policy

Is this a new policy with new training requirements or a change to an existing policy?	Existing
If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.	Continued knowledge and skills in relation to the recent legislation introduction.
Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice? Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHS Resolutions etc. Please identify the risks if training does not occur.	Communication of policy existence; training and awareness in referral and assessment including forms; training in the use of the act and skills in assessing.
Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.	Staff who have contact with service users staff (or managers of these staff)
Is there a staff group that should be prioritised for this training / awareness?	Awareness of policy and MCA, understanding of responsibilities and practice & updated documentation
Please outline how the training will be delivered. Include who will deliver it and by what method. The following may be useful to consider: Team brief/e bulletin of summary Management cascade Newsletter/leaflets/payslip attachment Focus groups for those concerned Local Induction Training Awareness sessions for those affected by the new policy Local demonstrations of techniques/equipment with reference documentation Staff Handbook Summary for easy reference Taught Session; E Learning	Rolling training programme of awareness training targeted to care staff throughout the organisation already established. Detailed training sessions targeted towards teams and specific groups as required by individual teams. Policy awareness through existing management meetings and bulletins.
Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.	Mental Health Legislation Development Lead

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Appendix B – continued

Training Needs Analysis

Staff/Professional Group	Type of training	Duration of Training	Frequency of Training
All Staff of the trust having contact with service users.	Overview of the main concepts of the act; the principles underpinning the Act; the assessment of mental capacity; the concept of 'best interests' and how this is determined; planning ahead for loss of capacity and the role of the Independent Mental Capacity Advocate	As indicated by specific course for individual Professional/Staff Group	3 years
All Staff of the trust assessing and making capacity decisions with service users.	This will provide a greater understanding of the MCA's implementation and implications for practitioners, update on operational requirements and provide some opportunity to apply and problem solve specific service issues. These will be delivered individually with teams.	As indicated by specific course for individual Professional/Staff Group	As required with changes in legislation or guidance
Professionally qualified care staff who provide care for service users and need to consider consent issues	Consent to treatment under the Mental Health Act 1983	As indicated by specific course for individual Professional/Staff Group	3 yearly

Copy of completed form to be sent to:

Training and Development Department,
St. Nicholas Hospital

Should any advice be required, please contact:- 0191 245 6777 (internal 56777-Option 1)

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix C

Monitoring Tool

Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

NTW(C)34 – Mental Capacity Act Policy - Monitoring Framework			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implementation and Monitored;** (this will usually be via the relevant Governance Group).
1.	Training in MHA/MCA/DoLS - 90% of Clinical Staff will have undertaken 3yrly NTW training	Data will be monitored (minimum bi-monthly) via Dashboards by line managers. Workforce Report.	Group Quality and Performance Sub-Group - Effective
2.	Assessment incorporates the patient's views and understanding of their problems. Including statements of capacity/incapacity.	Annual through QMT audit cycle undertaken by Team/Ward Manager.	Group Quality and Performance Sub-Group - Effective
3.	Evidence of involvement of the Patient and their family/carer, including Advance Decisions and Advance Statements.	Annual through QMT audit cycle undertaken by Team/Ward Manager.	Group Quality and Performance Sub-Group - Effective

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Governance Group in line with the frequency set out.