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**MENTAL CAPACITY ACT GUIDANCE**

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**MENTAL CAPACITY ACT GUIDANCE**

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**MENTAL CAPACITY ACT**

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**MENTAL CAPACITY ACT**

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| **1** | **BACKGROUND** |
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| 1.1 | Professional duties where a person’s mental capacity is suspected as impacting upon decision making is set in England and Wales by the 2005 Mental Capacity Act (MCA) legislation and Deprivation of Liberty Safeguards (DoLS) through the Mental Health Act 2007. This is further supplemented with 2 publications aiming to assist in the legalisation’s application, the Mental Capacity Code of Practice (published in 2007) and the Deprivation of Liberty Safeguards Code of Practice (published in 2008). |
|  |  |
| 1.2 | In 2014 two events had a significant impact on the legislation and how it is implemented. The first was a report by the House of Lords Select Committee entitled *‘Mental Capacity Act: Post Legislative Scrutiny’* which was critical of the DoLS legislation stating *“The provisions are poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act”.* It went onto state *“The only appropriate recommendation in the face of such criticism is to start again.”* In regard to the general provisions of the Mental Capacity Act the report is supportive commenting that it is *“a visionary piece of legislation for its time, which marked a turning point in the statutory rights of people who may lack capacity”* and *“Our findings suggest that the Act, in the main, continues to be held in high regard.”* It does however raise issues with how it is implemented. |
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| 1.3 | The second event was a Supreme Court case law judgement ***Cheshire West and Chester Council v P [2014] UKSC 19*** which significantly expanded the number of people requiring assessment under the DoLS scheme. This created a situation whereby it was not possible for many local authorities to meet their statutory duties under the legislation leading to significant waiting lists. It also led to a situation within health where the risk of unlawful deprivation of liberty for patients in hospital or subject to CHC increased significantly |
|  |  |
| 1.4 | An alternative scheme commonly known as the Liberty Protection Safeguards (LPS) was proposed in the Mental Capacity (Amendment) Act 2019 was passed into law. In addition to the replacement DoLS scheme the new legislation also contained updates and amendments to the MCA itself. Unfortunately, the actual implementation of this was delayed due to the Covid pandemic and in March 2022 the Department of Health and Social Care announced that the new legislation *“would not be implemented within the lifetime of this Parliament.”* This means that the DoLS legislation will remain in place until a future government takes an active decision to progress it. |
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| 1.5 | As part of preparations for LPS, work had started on a joint MCA / LPS Code of Practice with a draft shared for an extensive consultation. This aimed to provide practical guidance on LPS alongside a necessary update to MCA Code of Practice. Whilst the government has stated its intention to publish the MCA element of the above, at the time of writing no specific timescale has been offered. |
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| **2** | **PURPOSE** |
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| 2.1 | Since the MCA Code of Practice was published in 2007 there has been a wealth of case law, research, and guidance. In addition to this practitioners have gained a great deal of experience in applying the legislation. In the absence of an up to date national code of practice this guidance will aim to draw upon these wider sources. It also attempts to draw in the professional experience of staff and suggest solutions to commonly experienced problems. Several years preparations for LPS have also identified gaps in MCA practice and areas of concern that require action. |
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| **3** | **SCOPE** |
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| 3.1 | This document aims to ensure that local practice is not only compliant with the central tenets of MCA legislation but also serves to promote the underpinning values of positive risk taking and the protection of individual human rights bound up within the legislation. |
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| 3.2 | This guidance has been developed by Somerset ICB with the support of Somerset Foundation Trust. It is structured around the capacity and best interests pro forma developed by Somerset Foundation Trust. The guidance has been written in this manner mindful of the large quantity of information that practitioners are expected to consider. This formulation should better enable practitioners to link guidance with information requested on the pro forma where there may be gaps in their knowledge and understanding. |
|  |  |
| 3.3 | The aim of this document is to assist with the general provisions of the Mental Capacity Act. Further guidance regarding deprivation of liberty may be found in the ICB Mental Capacity Act & Deprivation of Liberty Policy. |

**NHS no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Forename: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  
**D.o.B**: \_\_\_ / \_\_\_ / \_\_\_

**Mental Capacity Assessment**

(Mental Capacity Act 2005)

To be kept in patients records when completed.

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| This form should be used to record an assessment of capacity where there is cause to question that person’s capacity to make their own decision (the person must be aged 16+). The Mental Capacity Act 2005 states that ‘**any assessment of capacity is time and decision specific’**.  Please note: a separate capacity assessment form should be completed for each decision. **(c)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and Job Title of person completing this assessment (a)** | **Date and Time of Assessment (b)** | | |
| **What is the specific decision that the person needs to make? (c)** | | | |
|  | | | |
| **Does this decision need to be taken now? (d)** | | **Yes** | **No** |
| Please state reason for this decision. Can the decision be delayed until the person’s capacity improves? | | | |
| **What is the relevant information for this decision? (e)** | | | |
| This should be tailored to the decision. It may include (but not be limited to): why the decision is needed, what the person’s situation or condition is, what options are available to them and what each of these involve, and the likely benefits or risks involved for each option, or of making no decision. | | | |

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| **What steps have been taken to support the person to make or be involved in this decision? (f)** |
| e.g. consideration of best time/place, use of communication aids, use of interpreter if required, possible effects of medication minimised, familiar face to support them. |

**Assessment of Capacity**

|  |  |  |
| --- | --- | --- |
| 1. **Do you consider the person is able to understand the information relevant to the decision to be made? (g)** | **Yes** | **No** |
| Summarise how you reached your conclusion by reference to the relevant information and why you believe the person understands or does not understand this. | | |
| 1. **Do you consider the person is able to retain the information for long enough to use it in order to make the decision? (h)** | **Yes** | **No** |
| Summarise how you reached your conclusion. What is the evidence that the person can or cannot retain the information for the time needed. | | |
| 1. **Do you consider the person is able to use or weigh that information as part of the decision-making process? (i)** | **Yes** | **No** |
| Summarise how you reached your conclusion. Was the person able to consider the advantages and disadvantages of possible outcomes and relate this to their own situation? Were they able to adjust their view in the light of new information? Could they see the different parts of the argument and decide how much weight to apply to them? | | |
| 1. **Do you consider the person is able to communicate their decision? (j)** | **Yes** | **No** |
| Communication can be in any way that is understandable. Summarise how you reached your conclusion. Explain how the person communicated their decision, or why they could not. | | |

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| --- | --- |
| **Outcome of assessment: (k)** | **Tick** |
| If the answer to **All** questions 1-4 is **Yes**  The person**HAS CAPACITY**at this time for this decision. |  |
| If the answer to **Any** of the questions 1-4 is **No**  The person **DOES NOT HAVE CAPACITY** at this time for this decision. |  |
| **If you have ticked “does not have capacity” you must now detail below the impairment of, or disturbance in, the functioning of the person’s mind or brain, AND how this causes their inability to make the decision. (l)** | | |
| **[Please note]** if you believe that the person’s decision-making ability is being impacted by undue influence or coercion from another party you should seek advice from MCA / safeguarding specialists.[[1]](#footnote-1) | | |

**NEXT STEPS**

**If the person has been assessed as having capacity to make the decision themselves**

You must respect the persons decision. This applies even if the decision may seem unwise. ‘Safety net’ where possible and document what this looks like. Consider seeking advice from MCA / Safeguarding specialists where risks are considered to be significant.

**If the person has been assessed as lacking capacity to make the decision**

Unless there is a valid and applicable advance decision, or another person has the authority to make this decision (for example a *Power of Attorney or a Court Appointed Deputy*), a decision must now be made following the best interest’s process. (Complete the Best Interest form).

**NOTES TO SUPPORT COMPLETING THE MENTAL CAPACITY ASSESSMENT FORM**

This mental capacity assessment form is intended to record a single capacity assessment about a single specific decision. Before you assess a person’s capacity you should be clear about what the decision is that they need to make, and the details of what options are available to them to choose from.

The professional who is providing or organising the care or treatment (the ‘decision-maker’) will usually be the right person to assess capacity. It may be helpful to seek advice about an individual’s understanding or cognitive abilities from an expert, and in these cases the decision-maker should take that advice into account in completing their assessment.

The court has provided guidance on the relevant information that should be discussed for the following specific types of decision:

|  |  |
| --- | --- |
| * Marriage * Care * Residence * Medical treatment * Contact * Sexual relations | * Contraception * Admission to hospital * Hoarding and belongings * Conducting proceedings * Deprivation of liberty |

If you are supporting a person and assessing their capacity to make a one of the types of decision listed above you will need to make sure that you have followed the guidance set out by the courts. You can view a summary of the court guidance in the *Mental Capacity guidance note: Relevant information for different categories of decision* produced by 39 Essex Chambers and found here: <https://www.39essex.com/information-hub/mental-capacity-resource-centre/mental-capacity-resources/mental-capacity-guidance> . You should contact the MCA specialists if you need support in planning a capacity assessment.

An assessment of capacity is made on the ‘balance of probabilities’. To conclude that a person lacks capacity for a specific decision you must be able to show that it is more likely than not that they cannot make the decision for themselves

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in making their own decisions. This may often involve explaining what is involved in very simple language, using pictures and communication and decision aids as appropriate. People close to the patient (family / friends) may often be able to help. There are also a range of specialist colleagues available to support practitioners- such as speech and language therapists, learning disability specialist team, psychiatric liaison teams, as well as independent advocates and interpreter services.

1. ***Name and Job Title of person completing this assessment:***

The Mental Capacity Act is an all-encompassing piece of legislation that is designed to be applied in many different contexts and applies both to professionals and lay people. Problems can arise however when determining who has the responsibility to carry out the assessment. If this is not clear or there is dispute as to who should progress an assessment it can lead to the assessment not taking place.

The MCA 2005 Code of Practice gives advice regarding this issue between 4.38 and 4.43. In regard to simple informal decisions the Code states:

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

*“For most day to day decisions, this will be the person caring for them at the time the decision must be made”*

Celeste and Aaliyah (carer)

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| Aaliyah is a domiciliary carer who visits Celeste in her own home. Celeste has a diagnosis of dementia. Whilst there Aaliyah heats up a meal for Celeste, makes sure she takes her medication, and supports her with washing and dressing. Celeste often states that she does not require help with washing and dressing or taking her medication, believing that she has already done it herself. Aaliyah will often continue to encourage Celeste with personal care and medication (in Celeste’s Best Interests) rather than accepting her assertions at face value as she has a ‘reasonable belief’ that she LACKS capacity in these areas. |

4.40 and 4.42 deal with ‘professional’ assessment and state that where a doctor or healthcare professional is proposing a treatment or examination; i) it is their responsibility to assess capacity to consent and ii) complex decisions are likely to require formal assessment. They can devolve or share this assessment with other professionals, but it is ultimately their responsibility to ensure the assessment is completed.

*4.42 – “…the final decision about a person’s capacity must be made by the person intending to make the decision or carry out the action on behalf of the person.”*

Often identifying the relevant person to complete a capacity assessment is a relatively straightforward exercise. Some examples in common decision making domains are listed below. *Please note that this list is for guidance only* *and may change with the specific circumstances of the case.*

* Capacity in regard to consent to medication – medic / nurse
* Capacity in regard consent to specific treatment / investigation – medic / nurse / physio / OT / SaLT
* Capacity in regard to where person resides for their care and support {care, support, and treatment in hospital} – medic / nurse / physio / OT/ SaLT
* Capacity in regard to where person resides for their care and support {discharge destination from hospital - Local Authority funded} – social worker
* Capacity in regard to where person resides for their care and support {discharge destination from hospital - CHC funded} – CHC nurse

On other occasions it can be less clear who the relevant professional is. For instance; i) if the decision being made lies outside the boundary of health care interventions but is linked to them (e.g. tenancy agreements / finances) ii) The most suitable professional to carry out the assessment may not be involved or available, iii) The decision in question could come under the remit of several professionals, iv) The capacity decision in question may not be one that the assessor intends carrying out on the person’s behalf e.g. decisions in regard to contact and sex. (see 4.42 above). 2 case studies and possible solutions are offered below. The Asif/Andrzej case study considers where there is an issue with the availability of an assessor, The Elena/Millie case study looks at where the responsibility for assessment is unclear.

Asif and Andrzej (dentist)

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| Asif has moderate learning disabilities and has recently been displaying aggression towards his family and carers. His mother believes that it is related to dental pain as she has noticed him refusing food and agitation around mealtimes. An appointment is made with the dentist (Andrzej) and an abscess diagnosed with a root canal decided on as an appropriate course of treatment. However the investigation proves distressing for Asif and he states that he will not have anyone “look in my mouth”. It is thought that a general anaesthetic (GA) will be required to undertake this. Andrzej works in a dental hospital and is not employed to undertake outreach work in the community. As the hospital environment itself appears to cause Asif anxiety it is felt the best place to support him with making this decision is at home. Asif reaches out to the local CLDT (Community Learning Disability Team) to support him with the assessment. They discuss the case and agree that on this occasion there is insufficient time to arrange a program of dental hospital desensitisation visits considering the pain and distress that Asif is experiencing. Andrzej shares with the CLDT nurse the relevant information in regard to the root canal treatment and the GA. The CLDT nurse carries out the assessment with Asif at home when he is calm and has the support of his mother. The LD nurse comes to the conclusion that Asif LACKS capacity to consent to the proposed treatment and forwards the assessment to Andrzej. Andrzej reviews and agrees the assessment as the ‘decision maker’ for the proposed treatment. He then organises a Best Interests meeting to consider next steps. |

Elena and Millie (ward sister)

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| Elena is a 19 year old woman with a diagnosis of Bi-Polar disorder. She is being nursed in a side room on a general medical ward following a suicide attempt but is not receiving 1:1 as she is no longer deemed high risk following assessment by the psych liaison team. During her stay Millie notes that she is visited by a man in his 40’s, John. When Millie asks who he is Elena identifies as her ‘partner’. Elena and her partner insist that the door is closed and that staff knock when entering. Millie becomes concerned regarding his visits as Elena is noticeably anxious before and distressed afterwards. After several visits Millie also starts to notice a deterioration in Elena’s mental health with symptoms of her bi-polar becoming evident. Millie approaches Elena to see if she wants any support but Elena’s mood is noticeably elevated, and she tells Mille aggressively to “mind her own business”. Millie feels out of her depth and approaches the psych liaison team for help. They state that they are unable to help as it is a risk issue for the ward to manage. Millie agrees with this to a point but states that she is unable to judge the degree to which Elena’s bi-polar is affecting her decision making. An emergency meeting is called on the ward because of the concerns. An agreement is reached that both Millie and a psych liaison nurse will jointly assess Elena’s capacity in regard to contact with John *together*. The trust Safeguarding nurse in attendance notes that if Elena is deemed to LACK capacity and a decision is made to prevent contact then legal advice must be sought from the Trust solicitors as it is a possible breach of Elena’s Article 8 human rights (family life and privacy). |

Principle 1(2) of the Act states that “A person must be assumed to have capacity unless it is established that he lacks capacity.” Effectively this means that the onus is upon the professional questioning the individual’s mental capacity to prove that they LACK, rather than the person having to prove that they HAVE. A useful way of thinking about this is that the assumption of capacity is the ‘starting point’ for considering the issue.

The assumption of capacity must not be used as justification for not assessing capacity where it is required. For example Swift J in ***Royal Bank of Scotland PLC v AB {2020} UKEAT***states *“The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult.”*

This issue is further articulated in ***Learning from SARS: A report for the London Safeguarding Adults Board (July 2017)***. This is an analysis of themes in Safeguarding Adults Reviews (SAR’s) commissioned and completed by London Safeguarding Adults Boards since the implementation of the 2014 Care Act. It comments *“Seven reports comment on the impact of practitioners making an insufficiently tested presumption of capacity, sometimes in relation to quite significant decisions on medical treatment or on self-care, because capacity was assumed, there were missed opportunities to balance choice and independence with the need for protection and safety.”*

Albert and Martha (district nurse)

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| Albert a gentleman with long term chronic mental health issues lives on his own and has a pressure sores that have developed on his heels. Martha tries on several occasions to persuade him to accept treatment for them with no success. In the end Albert is rude and aggressive to Martha. She returns to her base and records in the notes that Albert *“…had the capacity to tell me that he did not want treatment for his pressure sores”* Martha withdraws from future visits and emails the CPN asking her to contact her if she can get him to agree to treatment. Albert subsequently becomes ill with sepsis and dies. A Safeguarding Adults Review (SaR) is convened where it is noted that a number of professionals aside from Martha were involved (GP / CPN / Social Worker) but no formal assessment of his capacity in any decision making domain was completed. The SaR notes that “an ability to refuse treatment or state a preference does not mean that the person has capacity” |

1. ***Date and Time of Assessment***

As is made clear in the MCA Code of Practice Capacity is time and date specific. This can often cause some confusion with practitioners regarding questions such as ‘How long is an assessment of capacity valid for?’ and ‘Is there a set time in which I should review an assessment?’ The answers to these questions depend very much on the individual’s presentation and circumstances. If a formal assessment has been completed and you observe no difference in the individual’s presentation then you may proceed under the reasonable belief that they LACK capacity. This is with the caveat that the more time that has passed since the assessment was completed the less likely it is to map onto the circumstances in which the decision was originally made. Capacity status therefore should be kept under regular review. Should the individual’s cognition change however then this should prompt a re-assessment of their capacity as soon as is possible.

Liam and Juan (staff nurse)

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| Liam is being treated on Juan’s ward and for a delirium related to an underlying infection. The ward sister completed a mental capacity assessment regarding his antibiotics several days ago as Liam was refusing to take them. Liam was found to LACK capacity via a formal assessment and following a Best Interests process it was agreed that he should have these administered covertly. During the morning drug round Juan is worried about hiding the medication as per the care plan as the capacity assessment is now several days old. He speaks to the ward sister who asks him if Liam is presenting any differently to when the assessment was completed. Juan states that he remains confused and disorientated so the ward sister informs Juan that he may proceed under the reasonable belief that Liam lacks capacity. Several days later however as the antibiotics begin to take affect Liam’s cognition improves. Juan can no longer rely on the reasonable belief and looks to arrange a re-assessment of his capacity. |

1. ***What is the specific decision that the person needs to make?***

The Mental Capacity Act states that consideration of capacity is decision specific and must be assessed in this context. This means that capacity must not be expressed in relation to the person generally (e.g. The person has / lacks capacity in regard to *all decisions*) but in relation to a specific decision at a specific time (e.g. The person has / lacks capacity in regard to a Covid vaccination).

It is essential to consider how to formulate the decision in question. Sometimes this will be relatively straightforward, such as the example above and Covid vaccination. At other times however this will require more thought. For instance is the decision in question a patient decision or a clinical one? Is the decision in question connected in some way to another decision? Is the decision that is being assessed a ‘micro’ or a ‘macro’ decision. How can I ensure that I am not creating bias in the phrasing of the decision?

**Patient / Clinical decisions** – An important principle to consider here is expressed in***Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67*** which states *“ ...no patient can demand particular medical treatment which clinicians do not consider appropriate to offer”.* In a hospital orclinical context a clinical decision details what treatments are ‘on the menu’. The patient decision using the legal framework of the MCA then becomes about choosing between (or refusing all) the treatments that are offered. If there is only one treatment offered then the patient choice relates to accepting or refusing that treatment.

Gary and Dr Betts (Registrar)

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| Gary is 42 and has a progressive neurological condition has been admitted to a ward. Dr Betts discusses a treatment escalation plan with him including consideration of a DNaCPR (defined as a medical treatment). Dr Betts states that CPR is an *available* treatment option as Gary has minor physical co-morbidities and in her view resuscitation could work. Gary initially states that would want to be resuscitated to maximise the time with his family and so Dr Betts and Gary agree that for the time being the benefits of CPR outweigh the burdens. However the following week Gary asks to see Dr Bett’s and states that he has been thinking the matter over and does not want to be resuscitated. Whilst talking to Gary about this Dr Betts is assessing Gary’s mental capacity to make this decision. |

**Connected decisions** – Whilst it is important to recognise the ‘decision specific’ nature of the Act in reality individual’s lives are complicated and decisions they make can be inter-connected. Thus a decision that they make in one part of their lives may impact on their decision making elsewhere. ***B v A Local Authority (2019) EWCA Civ 913*** warns against capacity assessment outcomes in different areas which create an “*irreconcilable conflict”.* In this particular case a finding that the individual HAD capacity in regard to residence and LACKED in regard to sex made providing care and treatment for the person *“practically impossible”.* If an individual LACKS capacity in regard to sex (and is seeking intimate relationships with another) then this will impact on the care, support, and supervision they may require. Put another way the issue of residence is inextricably linked to the sex question within the specific context of this case and could not be meaningfully considered as a separate issue.

Jakub and Madelaine (Community Psychiatric Nurse)

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| Jakub lives in a group home with 6 other men. He is suffering with cognitive decline possibly as a result of excessive alcohol use. He is under an urgent DoLS having been deemed to LACK capacity in regard to his residence and care. Whilst he has to be back at the home each night he is allowed to access the community independently as the impairment is mild and the home have assessed him to HAVE capacity in regard to consumption of alcohol. Unfortunately this is placing his placement at risk as he is returning to the property and becoming aggressive with staff and other service users. Madelaine questions how the capacity assessment has been formulated by the home. She argues that the care and support he requires is inextricably linked to his alcohol use and should be considered together. Madelaine supports the home to carry out a new assessment where his alcohol use and impact upon his residence and care arrangements are subsumed into the broader relevant information of a residence / care decision. |

Theabove case study is loosely based on  ***London Borough of Tower Hamlets v PB [2020] EWCOP 34*** which stated *“The (capacity) question is not whether PB will drink to excess: the question is whether he lacks capacity to make decisions about his residence and care. The question of whether he will drink to excess is part of that.”*

**Micro / Macro decisions** – When deciding the decision in question it may be necessary to consider if the decision should be considered as a micro decision (one off) or a macro decision (repeated). An example of a micro decision could be capacity in regard to a Flu vaccination. This is a micro decision that has to be made once a year. Contrasting against this might be decisions in regard to insulin administration in the context of diabetes treatment. This may be seen in ***Royal Borough of Greenwich v CDM [2019] EWCOP 32*** whereby the Court held that in this particular case it was appropriate to consider the many individual decisions regarding insulin administration as a whole. As was expressed in the above judgement *“Diabetes management is not a single decision but a coherent series of decisions over time”.* Other areas that may come into the macro decision area include the management of finances, property, and affairs as is articulated in ***A, B and C v X, Y and Z [2012] EWHC 2400 (COP)*** which states*“ … the general concept of managing affairs is an ongoing act and, therefore, quite unlike the specific act of making a will or making an enduring power of attorney. The management of affairs relates to a continuous state of affairs whose demands may be unpredictable and may occasionally be urgent.”* Whilst the case law referenced above helps guide professionals the nature of each decision and if it is ‘micro’ or ‘macro’ must be considered on the specific facts of the case.

Other case law such as ***Sunderland City Council v AS and Others [2020] EWCOP 13*** alsosupports the use of assessing capacity over a longer period or and completion of a ‘longitudinal’ assessment.

**Unconscious Bias** - Care must be taken to phrase the decision as neutrally as possible. This is not just an exercise in semantics but helps practitioners from inadvertently conflating capacity assessment and best interests at the very start of the process. A decision about an individual wanting to return home without a package of care might be expressed as ‘Does P have capacity in regard to making safe decisions about a return home’. What constitutes a ‘safe decision’ however is likely a value judgement made by the professional. A better formulation of this question would be ‘Does P have capacity in regard to where they reside for their care and support? This formulation allows more space for positives and negatives to be considered, the first may inadvertently weigh the discussion around the professional view of risk.

1. ***Does this decision need to be taken now?***

Section 4(3) of the Mental Capacity Act states, s(he) (the assessor) must consider:

1. whether it is likely that the person will at some time have capacity in relation to the matter in question, and
2. if it appears likely that (s)he will, when that is likely to be.

Albert and Mary (staff nurse)

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| Albert is admitted onto the medical admission unit where Mary works. He is currently suffering with a delirium which is causing him to experience agitation and confusion. His daughter visits the ward in a distressed state saying that the time has come for Albert to move into a care home. Mary points out that she will assess his capacity in regard to his stay in hospital today and apply for a DoLS if he is deemed to lack. In regard to the decision regarding discharge Mary points out that Albert is on a course of antibiotics and that it’s likely that his confusion is linked to his delirium and temporary. She explains to Albert’s daughter that she will arrange for Alberts capacity in regard to discharge to be assessed after the antibiotic regime has had time to take effect. |

1. ***What is the relevant information for this decision?***

The Mental Capacity Act (2005) at 3(1) states that a person will lack mental capacity if they are unable to understand, retain, use or weigh, and communicate the relevant information to the decision at hand.Considering the ‘decision specific’ and person centred nature of the Mental Capacity Act it follows that relevant information will depend upon; a) the decision to be made and b) individual circumstances and risks. There have been a number of cases whereby the relevant information for specific decisions have been discussed in the Courts. Some common decisions and their relevant cases are listed below:

Marriage - LB Southwark v KA (Capacity to Marry) [2016] EWCOP 20

Care - LBX v K, L and M [2013] EWHC 3230 (Fam)

Residence - LBX v K, L and M [2013] EWHC 3230 (Fam)

Medical treatment - Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP)

Contact - LBX v K, L and M [2013] EWHC 3230 (Fam)

Sexual relations - A Local Authority v JB [2021] UKSC 52

Contraception - A Local Authority v A [2010] EWHC

Hoarding and belongings - AC and GC (Capacity: Hoarding: Best Interests) [2022] EWCOP 39.

Conducting proceedings - Masterman-Lister v Brutton & Co [2003] 3 All ER 162

Deprivation of liberty - A Primary Care Trust v LDV & Ors [2013] EWHC 272 (Fam)

When using the information in these cases it is important to note that the judgements should be viewed as ‘guidelines rather than tramlines’. Put another way it is not necessary to stick rigidly to the criteria set in the case law. Rather the criteria should be adapted to the individual circumstances and facts of the person you are considering. ***(B v A Local Authority {2019} EWCA Civ 913 and London Borough of Tower Hamlets v Anor {2020} EWCOP 21)***

Jim and Narveen (CHC Nurse)

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| Narveen is a CHC Nurse responsible for Jim, a 19 year old who has suffered a brain injury. She needs to assess his mental capacity in regard to discharge from hospital. She considers the ***LBX v K, L and M [2013] EWHC 3230 (Fam)***case law in regard to ‘residence’. One element states that the person must understand *“The two (or more) options for living”.* Narveen is aware that despite an extensive search only one residential home has been identified that can meet his complex needs. Narveen adapts this to *“that there is only one residential option currently available and that he has no ‘criteria to reside’ in the hospital”.* Further down the case law list it details that the person must understand *“The risk that a family member or other contact may not wish to see the person being assessed should they choose a particular placement against their family’s wishes.”*  As there is only one placement on offer and Jim has good relationships with his family Narveen omits this from the list. |

Where there is no case law to guide the content of relevant information then it is the responsibility of the person assessing capacity to determine what this should be. In this respect case law warns assessors about the ‘protection imperative’ and setting the bar too high. Justice Munby in ***Sheffield City Council v E { 2004 } EWHC 2808 ( Fam )***states *“We must be careful not to set the test of capacity to high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled”.* Justice Macur in***LBL v RYJ {2010} EWHC 2665 (COP)*** develops this further stating *“It is unnecessary that (s)he should be able to give weight to every consideration that would be utilised in formulating a decision…the person under review must weigh the salient details relevant to the decision to be made.”* Most recently this was endorsed in ***A Local Authority v JB {2021} UKSC 52*** which states “*To require a potentially incapacitous person to be capable of envisaging more consequences than persons of full capacity would derogate from personal autonomy”* The Mental Capacity Act at 3(4) states that “The information relevant to a decision includes information about the reasonably foreseeable consequences of— (a) deciding one way or another, or (b) failing to make the decision.”

Amy and Dr Bartholomew (GP)

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| Amy has learning disabilities and epilepsy and lives at home with a small package of care. She has recently experienced some absence seizures and her carers state that she often refusing to take her anticonvulsant medication when they offer them. Dr Bartholomew decides that the following is the ‘relevant information’*; i) The decision in question is about taking anti-seizure medication, ii) The medication is prescribed to stop her absence seizures and is taken 3 times a day, iii) If she does not take it or only takes in now and again it is likely that she will have more absence seizures, iv) that she has not reported any side effects but does find taking them to be ‘a pain’ v) That uncontrolled seizures might expose her to other serious risks in certain circumstances (bathing, preparing food).* Dr Bartholomew considers adding *vi) that without anticonvulsants she could develop tonic clonic seizures.* However, she decides that there is no sound basis for this and that it not a *reasonably foreseeable* consequence of failing to take the medication. Dr Bartholomew records the above relevant information in the ‘understand’ section of the capacity assessment alongside some verbatim responses and analysis detailing what she thinks Amy can or cannot understand |

***f) What steps have been taken to support the person to make or be involved in this decision?***

Principle 1(3) of the MCA states *“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.”* The onus therefore is on the professional not just to test the person’s ability to grasp the issues but support them to make the decision. This will involve sharing the relevant information with them (identified at e) above in a manner that is appropriate to them.

An example of where an organisation failed in its duty to meet Principle 1(3) may be found at ***CH v A Metropolitan Council {2017} EWCOP 12.***This involved a couple with learning disabilities where the husband was deemed to lack capacity in regard to sex. It was agreed that a programme of sex education could help the husband gain capacity for this decision. The local authority were not criticised in regard to initial actions in separating the couple. They were criticised and had to pay significant damages for taking over a year to implement the sex education programme. CH was subsequently found to have capacity and their intimate relationship resumed.

This is in contrast with the approach taken in ***A Local Authority v JB {2021} UKSC 52*.** This involved a young woman with learning disabilities who was pregnant and deemed to lack capacity in regard to sex. In this regard she had received many educative sessions but had failed to make any progress. The Court in this case accepted that the local authority had met its duties in regard to Principle 1(3) of the Act.

Hamish and Mary (LD nurse)

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| Mary is supporting Hamish who has Downs Syndrome, a mild LD, and suffers with a fear of needles. He also has a respiratory weakness and so it is deemed important that he has his Covid vaccination, however he refuses when he finds out that it is an injection. Mary devises an educative and desensitisation plan with Hamish and his personal assistants. Over several months staff share the relevant information with him about the vaccination. A booklet using easy read information is given to him and staff are asked to run through this on a regular basis. He also has several visits to the GP surgery and actually learns to give an injection himself into an orange. When staff and Mary believe he is ready they take him to the surgery, assess his capacity which they deem him to have, and he consents to the injection. |

It is essential that the person is informed of the explicit purpose of the capacity assessment. If this is not made clear then they may not grasp the importance of engagement with you. This is highlighted in case law at ***LB Wandsworth v M and Ors [2017] EWHC 2435 (Fam)*** where it is stated *“it seems to me to be fundamental to the assessment that P is informed of the purpose of the assessment."*

***g) Do you consider the person is able to understand the information relevant to the decision to be made?***

This alongside the following 3 sections (g-understand, h-retain, i-use or weigh, j-communicate) is often referred to as the 1st stage of the capacity test. It is also called the functional test. The information that the person must understand is that which you have set through your considerations detailed in section e) above. A useful starting point is to consider, does the person understand the nature of the decision to be made and the purpose of the assessment?

The capacity assessor has a difficult job in balancing the need to put the person at ease whilst simultaneously ensuring that they are aware of the potential outcome of the assessment, essentially that others may make the decision on their behalf if they are deemed to LACK capacity. The capacity assessor will need to look for evidence that the person understands the individual elements of the relevant information. If the individual can understand the individual elements of relevant information then they would meet the requirement for this part of the assessment. The question as to if they can hold this information in their mind long enough to make the decision ‘at the material time’ is dealt with under *h-retain*. The question as to if they can pull their understanding of all the elements together and look at the ‘big picture’ is dealt with in *I - use or weigh*.

The Courts have given some helpful guidance on the level of detail that is required in the completion of capacity assessment, and this is detailed in ***North Bristol NHS Trust v R [2023] EWCOP 5***

*“Given the number of capacity assessments that are required to be carried out on a daily basis in multiple arenas, it would obviously be too onerous to require a highly detailed analysis in the document in which the capacity decision is recorded. However, a careful and succinct account of the formulation of the matter to be decided and the formulation of the relevant information in respect of that matter, together with a careful and concise account of how the relevant information was conveyed and with what result, would seem to the court to be the minimum that is required”*

Another way of stating this is to state that the assessment should include;

* The relevant information
* Some verbatim content of the discussion
* Other sources of information used
* Your analysis of the discussion

***(h) Do you consider the person is able to retain the information for long enough to use it in order to make the decision?***

Section 3(3) of the MCA states *“The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.”* This links to the 2nd statutory principle of the Act *“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.”* In practical terms the MCA Code of Practice suggests *“Items such as notebooks, photographs, posters, videos and voice recorders can help people record and retain information.”*

The statute and Code of Practice initially constrained professionals to carry out their capacity assessments in a time limited interview manner, the assertion being that individuals did not have to retain information over a longer period. This strongly validated a one off ‘snapshot’ approach. Subsequent case law however has broadened options for capacity assessment. Concepts of micro (one off) and macro (repeated) decisions were introduced ***(i.e. Royal Borough of Greenwich v CDM [2019] EWCOP 32)*** A micro decision for instance might include making a decision around receiving a vaccination. Conversely a macro decision could include making repeated decisions about receiving wound care several times a day. This opens the door for a different type of assessment, one that might be characterised as a ‘video’ rather than a ‘snapshot’ obtained in a single interview. In the context of macro decisions, a longitudinal *assessment* can occur over a period of time with the professional gathering information from different sources (accounts of others, clinical records, several interviews with the individual) and a *determination* being made once the evidence had been gathered. ***Sunderland City Council v AS and Others [2020] EWCOP 13***

Two case studies below are offered as examples of how the ‘retain’ element might be considered within the context of a micro and macro decision

Anne and Dr Jones (GP)

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| Anne is a care home resident with Dementia who has been booked in for her flu vaccination She is brought into the surgery with her daughter but when the injection is prepared by Dr Jones Anne insists that she had it yesterday and refuses accusing staff of “messing her about”. Her daughter brings out her phone and plays a short video that was taken the previous day. The video shows a discussion between Anne and a nurse whom she has a good relationship with at the care home about the vaccination. After watching this Anne relaxes visibly, Dr Jones runs through the pros and cons with her, deems her to have capacity and she is able to consent to the injection. Dr Jones characterises the decision as a micro decision. |

Ron and Charlie (Modern Matron)

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| In the day when Ron is alert Charlie assesses his capacity. Ron understands that he is being treated for sepsis and the life-threatening consequences for him should he try and leave. He is deemed by Charlie to HAVE capacity. Later on, however Ron becomes confused and attempts to leave the ward. Staff reassess his capacity urgently, decide that he LACKS and take steps to prevent him leaving in his Best Interests. The next day Charlie re-assesses his capacity and shares the ‘real world’ information gained from last night. Charlie attempts to explore with Ron the impact of his changing mental state on Ron’s decision making and safety. As Ron cannot recall the incident he states that staff are exaggerating. Ron is unable to offer any views on how he was at risk during the episode and how he may be in the future. Charlie reflects and decides that a ‘macro’ perspective regarding the capacity assessment applies in Ron’s case as he is making repeated attempts to leave. Charlie decides that even when at his most alert Ron LACKS capacity on the grounds that he cannot retain the relevant information at the material time. Charlie also applies for a DoLS Authorisation via the Local Authority. |

1. ***Do you consider the person is able to use or weigh that information as part of the decision-making process?***

This part of the capacity test is described in ***The PCT v P, AH and the Local Authority [2009] EW Misc 10*** as *“the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another.”* Another way of considering this criteria is that it is about the individual’s ability to show reasoning in relation to the decision that they are making. Whilst principle 4 of the MCA (*“A person is not to be treated as unable to make a decision merely because he makes an unwise decision”)* appears straightforward on paper in reality determining what is unwise and what is incapacitous can prove challenging. This is explored below in Lucy and Fred’s 3 part case study below.

Fred and Lucy (SaLT) (Part 1)

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| Fred has early onset dementia and experienced a stroke several years ago. He resides in a supported living scheme. Following a recent choking episode Lucy has determined that Fred has significant swallowing difficulties (dysphagia) and recommends that that he only eat a soft diet. Fred refuses so Lucy decides to assess his capacity in regard to eating and drinking. After sharing the relevant information with Fred she asks him about any advantages of her plan. Fred states that there are “none”. When she asks him to consider any disadvantages Fred states that “he doesn’t see why someone should tell him what to do”. Lucy prompts him to consider the matter in more detail, but Fred shuts down and refuses to talk anymore. |

In some cases capacity can be determined by discussing the pros and cons of the decision with the individual, then asking them to explain the reasoning for their decision. As may be seen from the case study offered above this will not always work for a number of reasons; i) The person may simply not want to acknowledge that there are any disadvantages to their preferred outcome, in our everyday lives we are more likely to stress the advantages to things that we want and minimise the disadvantages, ii) A lack of trust from the person being assessed. Professionals are often in a position of perceived and actual authority with patients. Individuals may be fearful that if they openly acknowledge difficulties then these will be used as evidence against them, iii) The person may be aware of their difficulties at some level but in denial about them. This may require a different approach as explored below.

Fred and Lucy (SaLT) (Part 2)

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| Lucy takes a little time out and chats to staff at the residence about Fred. She discovers that Fred was a bit of a “foodie” and that his wife recently passed away. She begins the next discussion with Fred talking about his life and interests. Lucy takes a different approach asking Fred if he can see why professionals might be worried and why? Fred acknowledges that he could *“choke and die”,* but *“eating proper food reminds me of time spent with my wife”.* Lucy asks about how he might reduce the risk of choking. Fred states that he’s *“not stupid”* and that he will *“make sure staff are about”* and *“isn’t going to be sucking boiled sweets anytime soon”.* Lucy comes to the conclusion that Fred HAS capacity clarifying that he is placing greater weight on the emotional pleasure and security that he derives from eating a normal diet. |

Court of Protection case law ***GM; FP v GM and A Health Board (2011) EWHC 2778 (COP), Cardiff Council*** **v** ***Peggy Ross (2011) COP 28/10/11 12063905***) has highlighted circumstances where professionals have given more weight to physical safety in MCA considerations. A common error in such circumstances is that professionals equate the individual’s disagreement with them in regard to the risk with a lack of capacity. As is stated in ***Macur in LBL v RYJ {2010} EWHC 2665 (COP)*** *“assessors must recognise that different individuals may give weight to different factors.”* Understanding the context of Fred’s life is essential here in understanding why his reasoning may differ and why the person may be placing a greater weight on their emotional well-being.

Additional challenges may be found when the impairment that the person is experiencing involves problems with their executive functioning. This can be present in conditions such as traumatic brain injury, frontotemporal dementia, and cerebral vascular accidents. Individuals with these conditions may show minimal impairment in regard to their global cognitive abilities but struggle with higher level executive functioning. Often this means difficulties with impulse control, emotional regulation, initiation, organising, rigidity of thought, and planning. As such individuals can appear at the point of assessment to be capacitous yet still place themselves at considerable risk ‘at the material time’ the decision needs to be made. Professionals will sometimes describe this as being able to “talk the talk but not walk the walk.”

Fred and Lucy (SaLT) (Part 3)

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| Several days later Lucy receives a call from the home. They inform her that Fred ate a boiled sweet and choked. Lucy calls Fred’s GP who informs Lucy that Fred experienced a stroke several years ago in his frontal lobe. She calls and speaks to Fred’s daughter who states *“my dad has changed, he used to be gentle but doesn’t seem able to control himself and his anger anymore”.* On arriving at the home Lucy speaks to staff who highlight that he is often impulsive around food and gets very angry if staff offer any advice. Lucy shares the observations of others she has gathered with Fred. She suggests that he may struggle to make decisions around food in the moment because of where his stroke was. Fred dismisses this maintaining that his thinking is no different now than before his stroke. Lucy points out the inconsistency with his previous statement around *“not eating boiled sweets”.* Fred responds that *“he can do what he likes”.* Lucy gently challenges Fred asking how; a) how his impulsivity in regard to food intake may place him at risk, b) what strategies that he might employ to ensure he doesn’t choke again. Despite the support offered by Lucy Fred is unable to acknowledge that he experiences any impulsivity or anger despite real world evidence to the contrary. Lucy revises her initial decision and decides that Fred LACKS capacity in regard to his eating and drinking. |

Case law such as ***Sunderland City Council v AS and Others [2020] EWCOP 13*** supports the notion that capacity assessment in these circumstances may consider evidence from a variety of sources and does not have to rely solely upon a direct interview with the individual. In the case study above Lucy (SaLT) gained ‘real world’ information from the GP, carers, and family which was then used to inform her decision and discussion with Fred. In such cases it is useful to distinguish between the assessment of capacity (which may occur over a period of time) and the determination of capacity (where the assessor reviews the information gathered and comes to a conclusion). Caution must be taken in these cases to distinguish between; i) situations where individuals have changed their minds at the point of making the decision and ii) situations where the individual is unable to use or weigh the information at the moment of the decision because of the nature of their mental impairment. Seeking stronger evidence in regard to the precise nature of the mental impairment (as discussed on page 31) is advised in these situations.

The discussion of executive function in the context of MCA / Safeguarding decision making has featured much more prominently in recent years. A range of terms such as executive capacity and frontal lobe paradox are now in common usage when exploring the difficulties and tensions that professionals face in practice. It is important to note however that these terms do not exist either within the Act itself or the respective MCA Code of Practice. Case law ***(Warrington Borough Council v Y and Ors {2023} EWCOP 27)*** warns against using descriptions and definitions such as these formulated in clinical practice as ‘equivalents’ to the capacity test specified in the MCA. What is required is a thorough consideration of the individual’s ability to use and weigh the relevant information *“at the material time.”*

Another key consideration when assessing capacity is determination and sharing of available options. At times this will be straightforward. For example following a hospital admission where a person now has care needs the decision may be shared with the individuals as; a) return home with no care, b) a return home with a package of care, or c) a move to a care home. Real world situations however can complicate matter as is seen in the case study below.

John and Barry (O/T) (part 1)

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| John who lives at home has Parkinson’s disease and is admitted to hospital following a fall. John is now medically fit for discharge and becoming increasingly agitated waiting for his care needs to be reassessed and wanting to return home. During discharge planning John’s family state that John is placing excessive demands on his wider family in particular his wife. They state that if he goes home them his wife’s mental health will suffer, and the wider family will not be able to provide any more support. They share the view that John’s needs can now only be met in a care home. John’s care needs are re-assessed, and two options are identified i) care at home with a package of care and ii) residence and care in a nursing home. Barry prompts the family to share their views with John directly, but no one feels able to do this. Barry aware of the case law criteria in ***LBX v K, L and M [2013] EWHC 3230 (Fam) (****“(j)The risk that a family member or other contact may not wish to see the person being assessed should they choose a particular placement against their family’s wishes.”)* states that John cannot be fairly tested on his ability to make this decision if he is not made aware of consequences of the decision. Family members reluctantly acknowledge this, and Barry supports them to inform John that they will no longer be willing to provide care and support for him. |

As stated in ***CC v KK and STCC [2012] EWHC 2136, (COP) [2012] COPLR 627*** *“Capacity assessors should not start with a blank canvas. The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed"* The above example highlights the tensions sometimes experienced between consideration of the ‘greater good’ (i.e. the emotional needs of his wife and wider family) and individual human rights (the safety and emotional needs of John). However the MCA is a human rights based piece of legislation which directs us to view the issue through the needs of the individual under assessment.

Capacity assessors also need to be aware of the limitations and constraints that there may be in regard to what options may be considered available. Both ***North Yorkshire CC v MAG and Another [2016] EWCOP 5N* and *N v ACCG [2017] UKSC 22*** highlight that any decision made using the framework of the MCA should be predicated by a decision regarding what resources are available to the case.

John and Barry (O/T) (part 2)

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| After John is informed of the family’s views he remains insistent that he wants to return home. The next day John’s wife states that she will move out of the family home if he returns. Barry’s wife is factored out of any care and support arrangements. John’s assessed care needs by the local authority state that he needs 24 hours 1:1 care with double ups 4 times a day. The offer of a package of care is removed as an available option as the local authority are of the view that his needs can now only be met in a care home. The local authority have followed a lawful process in coming to this decision around resources. John reassesses Barry’s capacity but on this occasion the options are reformulated for the capacity assessment as a) return home with no care and support , b) move to care home A, c) move to care home B. |

1. **Do you consider the person is able to communicate their decision?**

The MCA Code of Practice at 4.23 states that failing to meet the requirement for this limb of the capacity test will *“apply to very few people”.* It gives the examples of*;* i)people who are unconscious or in a coma, or ii) those with the very rare condition sometimes known as ‘locked-in syndrome’, who are conscious but cannot speak or move at all. However research by Rucke Keene et al (2021) suggests that this element has since been widened by the Courts to include the ability to express a stable preference.

Attempting to determine a reliable Yes / No response may be helpful to consider here where no reliable means of expressive communication is evident. The first point of call here will be to explore previous SaLT input or make a referral onwards. However, time considerations or a lack of availability often means that the assessor will need to seek information direct from a carer or family member who knows the person best. In these situations the assessor will be looking to identify any purposeful action an individual is able to make (eye pointing, verbalisations, squeezing a hand etc). The assessor would then share details of the relevant information with the person under assessment testing their ability to communicate through varying the manner in which the responses are requested.

Kalisha and Maja (CHC Nurse)

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| Kaleisha is 24 year old woman in receipt of CHC funding. She is non-verbal, has quadriplegia and severe learning disabilities. Following a safeguarding investigation her parents come to the view with professionals that her care needs will be best met in a care home. Maja talks to both of Kalisha’s parents in preparation for the capacity assessment. Her mother and father both state that Kaleisha will make a ‘clicking’ noise with her teeth when they discuss her favourite food (jelly) or activity (swimming). Maja then spends some time with Kaleisha talking to her and sharing the relevant information about the decision to be made verbally. She supplements this discussion with various picture resources. Maja then asks to Kalisha to make her clicking noise when she likes or agrees with something Maja has said and shown. Maja holds up a picture cards stating alternatively *“I like swimming / ice cream/ living here / living in a residential home”.* Maja completes the exercise a further 3 times changing the order that the pictures are presented in. Whilst Kaleisha does make an occasional ‘clicking’ sound Maja cannot determine any consistent response to the pictures / statements. Maja comes to the conclusion that Kaleisha is unable to understand the relevant information and also unable to communicate her decision. |

1. **Outcome of assessment**

It is important to note that in order to be deemed as having capacity the person must be able to successfully meet *all 4 elements*. They must be able to understand, retain, use or weigh, and communicate their decision.

It is important to note that the MCA Code of Practice (2005) is now incorrect as it has been superseded by case law. ***PC and NC v City of York Council [2013] EWCA Civ 478*** and subsequent refinements ***(A Local Authority v JB [2021] UKSC 52)*** now detail that assessors should:

i. First consider if the person is able to understand, retain, use or weigh, and communicate the relevant information

ii. Then consider if this is because of a mental impairment

This reverses the test as originally set out in the MCA Code of Practice which stated that the presence of a Mental Impairment must be ascertained first.

If you have determined that the person has been unable to meet the requirement for any of the 4 elements of the test in order to state that the person LACKS capacity *you must link it to a mental impairment in the next stage of the form.*

1. **If you have ticked “does not have capacity” you must now detail below the impairment of, or disturbance in, the functioning of the person’s mind or brain, AND how this causes their inability to make the decision.**

This is the second stage of the Mental Capacity Test. It is sometimes called the diagnostic test, but this is misleading as a formal diagnosis is not necessarily an essential requirement. It involves determining the presence of a Mental Impairment and making a causal link to the person’s inability to make the decision established above in the first stage / functional test.

Mental Impairment in the Act is defined as *“a disturbance in the functioning of the mind or brain ”.* The MCA 2005 Code of Practice gives the following examples;

*“conditions associated with some forms of mental illness, dementia, significant learning disabilities, the long term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion following head injury, the symptoms of alcohol or drug use“* ( NB. This list is not exclusive ).

As may be seen from the list above the definition of a Mental Impairment is broad and includes long term conditions (dementia / learning disabilities) alongside temporary altered states of consciousness (alcohol intoxication / delirium). Further examples detailing how wide the definition of mental impairment is may be seen in ***A NHS Foundation Trust v an Expectant Mother {2021} EWCOP23*** where agoraphobia is identified as a mental impairment and ***Cheshire West and Chester Council v PWK {2019} EWCOP 57*** where anxiety is identified as a mental impairment. There is no specific requirement for the mental impairment to match any clinical definitions such as those provided in the International Classification of Disease (ICD-10) or Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Determining if there is a link between these 2 stages is an essential part of the test and referred to as the ‘causative nexus’. Two case studies are offered below to illustrate this, the first where a link is present (+ve causative nexus) the second where it is not (-ve causative nexus)

Barbara and Harry (care home manager)

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| Barbara is an elderly lady who lives in a residential care home and has a diagnosis of dementia. She is independent within the home and often walks into the town centre each morning by herself to get the paper, this being an important part of her daily routine. Harry notices Barbara just as she is about to leave the home. It is the middle of winter, raining and Barbara does not have a coat on. When Harry asks where she is going Barbara appears disorientated and is unable to say. Harry is aware that Barbara has suffered with urine infections in the past which have caused her to become confused. He guides Barbara back to her room where he speaks to her and determines that she is unable to understand the relevant information regarding accessing the community independently. Harry believes that this is not because of her dementia (which is newly diagnosed and mild) but that it is linked to a delirium. A urine test later confirms this, and Barbara commences a course of antibiotics. |

Ivan and Kai (RMN)

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| Ivan is an informal patient on a psychiatric ward. He suffers with schizophrenia and was admitted after an acute psychotic episode. He has now had a medication review and is deemed well enough for discharge. Plans are made for him to return to his flat however following a visit from his mother he states that he wishes to return to live with her. Kai is concerned about this and shares with Ivan the relevant information (adapted from ***LBX v K, L and M [2013] EWHC 3230 (Fam)*** to his particular situation. He reminds Ivan of previous safeguarding concerns in regard to his mother’s coercive and controlling behaviour. He shares the professional experience that Ivan’s mother had been restricting access to mental health professionals and the professional view that this was what had led to his mental health breakdown. Ivan denies any coercive control and maintains that he wants to go back to his mother. Kai completes the capacity assessment recording his view that Ivan is unable to use or weigh the relevant information in regard to discharge destination. However he is unable to link it to Ivan’s mental impairment. Although Ivan has had schizophrenia for many years he is currently well. In Kai’s view the primary reason Ivan is unable to make the decision is because of the alleged controlling and coercive behaviour of his mother. Kai determines that Ivan HAS capacity in regard to the decision. Kai returns home to his mother and a repeat Safeguarding Adults referral is made |

Case law at ***(Pennine Acute Hospitals Trust v TM [2021] EWCOP 8)*** clarifies that a formal diagnosis is not an essential requirement of the capacity assessment. Similarly a Mental Impairment does not have to be listed within any medical classification tool (e.g. ICD10 or DSM-5) This means that it will often be sufficient to progress with the presence of symptoms and/or a working diagnosis. In these cases best practice would involve practitioners detailing the symptoms alongside their rationale for the working / suspected diagnosis. The broader context however is that a formal diagnosis or medical opinion will offer stronger evidence ***(North Bristol NHS Trust v R [2023] EWCOP 5).*** Stronger evidence will be helpful in certain cases particularly where an individual’s executive functioning is thought to be impacting on their decision making.

Professionals often report feeling of uncertainty when coming to a conclusive decision regarding capacity. These feelings of uncertainty can be further exacerbated when the risks inherent in any patient decision are high. It is worth noting that capacity as defined in the MCA in itself is a legal construct that asks us to draw an artificial bright line in regard to an individual’s cognition and decision-making ability. In reality of course an individual’s decision making, and cognition exists on a continuum which may add to any professional feelings of uncertainty. When coming to a decision professionals are asked to make their decision *on the balance of probabilities*. Professionals do not have be 100% certain of the outcome, they must believe that *it is more likely than not* that the person either HAS or LACKS capacity.

**NHS no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Forename: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  
**D.o.B**: \_\_\_ /\_\_\_ /\_\_\_

Best Interest Decision Record

(Mental Capacity Act 2005)

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| The decision maker completing this record must be satisfied that the person lacks the mental capacity to make the specific decision themselves and has not regained capacity since the capacity assessment was undertaken. The ‘Assessment of Mental Capacity’ form must have been completed.  In determining Best Interests, the decision maker must have regard to chapter 5 in the MCA Code of Practice and should avoid assumptions based on the person’s age, appearance, condition or behaviour(s).  A referral to the **Independent Mental Capacity Advocate (IMCA)** service should be made whenever a person who lacks mental capacity has no family or friends who are appropriate to consult in making a decision about:   1. serious medical treatment 2. long term care and health moves (more than 28 days in hospital / 8 weeks in a care home) |

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| **What is the specific decision that needs to be made? (a)** | | | | |
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| **Please describe the available options being considered: (b)** | | | | |
| If the decision is complex it may be helpful to document and explore these options using a ‘balance sheet’. Consider what is least restrictive. If the decision is complex or finely balanced, consider holding a best interest meeting. | | | | |
| **Option 1** | | | | |
| **Option 2** | | | | |
| **Option 3** | | | | |
| **If the decision is about medical treatment, has the person made an Advance Decision to refuse the treatment? (c)** | | | **Yes** | **No** |
| If ‘yes’ please evidence this below. The Advance Decision must be valid and applicable. Note: there are specific provisions if the refusal relates to life sustaining treatment. Guidance can be found at the end of the form. | | | | |
| **Does anyone hold a valid Lasting Power of Attorney or Court Appointed Deputyship giving them authority to make this decision? (d)** | | | **Yes** | **No** |
| If yes, the person(s) holding that LPA or deputyship is the decision-maker. A copy of the document must be viewed and stored in the patient’s file. Record name(s), legal role, and contact details below: | | | | |
| **Does this decision need to be taken now? (e)** | | | **Yes** | **No** |
| If the person’s capacity is likely to improve, consider if the decision can be delayed until then. | | | | |
| **Detail the individual’s past and present feelings and wishes in relation to the decision. Document any relevant values and beliefs held by the individual and anything else you believe they would take into account if they were making the decision (f)** | | | | |
| You must complete this section in full detail. | | | | |
| **Details of those consulted / involved in this decision making process: (g)**  Please see guidance at end of form about who should be consulted, including when an IMCA is required. | | | | |
| **Name** | **Role/Relationship** | **Date consulted and how consulted** | | |
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| **Details of persons / organisations not consulted (h)** | | |
| **Name** | **Role/Relationship** | **Reason not consulted / attempts made** |
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| **Summary of Best Interests decision-making (i)** | |
| Please document the risks and benefits of each option as viewed/shared by those consulted. Document any differing views about what is in the person’s best interest. | |
| **Document what action or decision has been reached in the person’s Best Interests (j)** | |
| There should be consensus about the decision from all those consulted. If there is any disagreement or dispute about what is in the individuals best interest you must contact MCA / Safeguarding specialists[[2]](#footnote-2) or seek legal advice. | |
| **Signature of lead decision maker** | **Date and Time** |
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| **Name and Job Title** | **Contact Details** |
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**FURTHER NOTES TO SUPPORT COMPLETING THIS FORM**

This guidance should be read in conjunction with the Mental capacity Act Code of Practice <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

**IMCA service**

A referral to the Independent Mental Capacity Advocate (IMCA) service should be made whenever a person who lacks mental capacity has no family or friends who are appropriate to consult in making a decision about:

1. Serious medical treatment
2. Long term care and health moves (more than 28 days in hospital / 8 weeks in a care home)

An IMCA has the same rights to challenge a decision as any other person caring for the patient or interested in their welfare. The right to challenge applies to both decisions about lack of capacity and a person’s best interest. The IMCA service for Somerset is provided by SWAN Advocacy <https://swanadvocacy.org.uk/refer/somerset/>

**Advance decisions**

If the adult now lacks capacity but has clearly refused particular treatment in advance of their loss of capacity within a valid and applicable Advanced Decision then you must abide by that refusal.

For an advanced decision in relation to life-sustaining treatment to be valid, it must be in writing stating specifically what situations and treatment it covers. It must also be signed and witnessed, and state clearly that it applies even where the person’s life is at risk.

If you have any concerns about an Advance Decision please contact MCA Specialists.

**Consulting others**

The following people should be consulted, so far as is reasonable to do so, when determining Best Interests:

* anyone named by the person as someone to be consulted on the matter in question
* anyone engaged in caring for the person
* anyone with an interest in their welfare including close relatives
* anyone who has been given a Lasting Power of Attorney by the person
* any deputy appointed for the person by the Court of Protection

**Disagreement about best interests and the Court of Protection**

Court of Protection approval may be required where there is disagreement about the patient’s capacity or best interests. If there is unresolvable disagreement about either capacity or best interests you should contact MCA / Safeguarding specialists.

Where treatment is complex and people close to the patient express doubts about the proposed treatment, a second opinion should be sought unless the urgency of the patient’s condition prevents this. Donation of regenerative tissue, non-therapeutic sterilisation, or treatment requiring significant levels of restraint must never be undertaken without prior discussion with the MCA / Safeguarding specialists and are likely to require approval from the Court of Protection.

**Lasting Powers of Attorney and Court Appointed Deputies**

If the patient lacks capacity a person with Deputyship or Lasting Power of Attorney (LPA) may have the authority to make the decision on the patient’s behalf acting in their best interests. You should always ask to see the original documentation or seek confirmation of authority from the Office of the Public Guardian via:

<https://www.gov.uk/government/publications/search-public-guardian-registers> or [View a lasting power of attorney - GOV.UK (www.gov.uk)](https://www.gov.uk/view-lasting-power-of-attorney)

Where there is an Advance Decision to Refuse Treatment and an LPA/Deputyship, the most recent instruction will apply.

An attorney has no power to consent to or refuse life-sustaining treatment unless the document expressly authorises this. A deputy never has the power to make life-sustaining treatment decisions.

If you have any concerns that an attorney or deputy may not be acting in the person’s best interest please contact MCA / Safeguarding specialists for advice.

1. **What is the specific decision that needs to be made?**

The guidance previously forwarded in this document in regard to identifying the capacity assessor also applies here. It is important to note that consideration of Best Interests only applies once the person has been assessed as LACKING capacity in the relevant decision making area. If a capacity assessment has not occurred or the capacity assessment is unrelated to the decision being made then the Best Interests process should stop, and arrangements made for a capacity assessment in the relevant domain.

Arthur and Lucy (LD community nurse)

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| Arthur who has mild learning disability and autism has been refusing his anticonvulsants following a recent medication review. Worried professionals call an MDT to discuss their concerns. At the start of the meeting attendees begin to refer to it as a Best Interests meeting. Lucy asks that it is not referred to as such as she is unaware of a capacity assessment that has been completed regarding his medication. A fellow attendee points out that Arthur is on a DoLS. Lucy responds stating that the DoLS capacity assessment would be for a different decision (where Arthur lives for his care and support). The meeting continues but the focus shifts to considering the possible reasons for refusal and how Arthur can be supported with his decision making. The meeting also considers who is the best professional / person to assess his capacity regarding medication. Professional views regarding the importance of taking the medication are sought with the aim of informing a future Best Interests decision if Arthur is deemed to LACK. This with the caveat that professional views may have to be revisited once Arthur and his family’s views have been gathered. |

1. **Please describe the available options being considered:**

The guidance detailed at ***CC v KK and STCC [2012] EWHC 2136, (COP) [2012] COPLR 627*** in regardto capacity assessment maps across to Best Interests considerations. Expressed another way, how can a professional charged with considering what is the person’s Best Interests achieve this without knowing what the options on the table actually are? The actual availability of options however will be impacted on by other factors which are explored below.

Care and Residence Context: Determining what is in an individual’s best interests will be constrained by a) the resources that commissioners have allocated to that person’s care and b) the actual availability of a residence or care that the person has been assessed as requiring. ***(North Yorkshire CC v MAG and Another [2016] EWCOP)***

Mohammed and Jenny (discharge nurse)

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| Mohammed is recovering from a stroke and due to be discharged home. He is deemed to lack capacity regarding this decision. An intermittent package of care has been set up for him however his family are unhappy with this. They state that he requires a 24-hour package of care and want to have a Best Interests meeting where the pros and cons of returning home with a package of care vs returning home with 24 care and support is discussed. Jenny explains that Mohammed has been assessed under the CHC provisions and found to be not eligible. She states that the local authority have assessed his needs and deemed this allocation of resource can meet his needs. She explains to the family that they must make the Best Interests decision within these parameters. |

Public bodies duties in regard to the commissioning of residence / care should occur before the related Best Interests decision. They should have robust policies and procedures in place to ensure that commissioning decisions follow due process and are made in an open and transparent manner. This will help to ensure that a clear line is drawn between a commissioning decision and an MCA based patient decision. ***N v ACCG [2017] UKSC 22*** highlights that decision makers / public bodies must avoid prematurely withdrawing options ostensibly for commissioning reasons when the actual goal is to override the persons, family, or IMCA’s input.

Medical Treatment Context:The same principle that is expressed above, that someone making Best Interest’s decisions on a person’s behalf may only make them within the context of what is available applies in the medical treatment domain. Case law at ***Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67*** states *“ ...no patient can demand particular medical treatment which clinicians do not consider appropriate to offer.”* This does not solely apply to capacitated patients but to those tasked with making decisions on their behalf under the Best Interests provisions. Clinicians must exercise caution that their own value judgements do not influence the clinical availability of treatment.

Fred and Dr Jones (GP)

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| Fred who has a learning disability visits Dr Jones with his father after developing flu symptoms. Fred is deemed to lack capacity regarding his prescribed medications. Fred’s father is understandably concerned and states that he is worried after his own recent experience that it may ‘go to Fred’s chest’ and asks Dr Jones to prescribe antibiotics in his ‘best interests’. Dr Jones explains that Fred is much younger than him and that he does not have the same comorbidities. He goes onto give his clinical view that antibiotics for Fred are not clinically indicated. |

When making best interests’ decisions it may take some time to understand what the actual concrete options are. For instance in a residence and care context it may take some time to determine an individual’s care needs on discharge and then to find available options for care. In a medical treatment context it may take some time to determine what is actually clinically indicated for that person Where the decision can be delayed until concrete options are available then this should occur. However it may be necessary to make related preliminary decision(s) prior to this.

1. **If the decision is about medical treatment, has the person made an Advance Decision to refuse the treatment?**

It is important to note that an Advance Decision to Refuse Treatment (ADRT) differs in nature from the authority granted to Lasting Power of Attorneys and Court Appointed Deputies. A valid and applicable ADRT carries the same weight as a decision made by a capacitated individual. That is to say that a Best Interests process does not apply as the decision is already made via the ADRT.

An ADRT is a process whereby an individual decides against receiving a particular health care intervention in advance before they have lost capacity to make that decision. It is a recording that the individual wishes to refuse consent to specified future treatment. It cannot be used to request or demand future treatment. These decisions may be given verbally or in writing. If they are in relation to the refusal of life sustaining treatment however, they must be in writing and signed by the individual and a witness. They also need to contain a statement confirming that the decision applies even if their life is at risk.

Professionals must also satisfy themselves that the ADRT is valid and applicable. This involves consideration of factors such as; a) is the proposed treatment or circumstances the same as that detailed on the ADRT, b) is there a conflict with decision making under another authority such as Lasting Power of Attorney, c) has there been a significant change in the persons circumstances or behaviour that would indicate their decision may now be different. Professionals should seek the support of Mental Capacity specialists where the situation is contentious or the ADRT involves refusal to consent to life sustaining treatment.

Whilst the general provisions of the Mental Capacity Act apply from age 16 an individual must be 18 years of age at the time of writing in order for one to be valid. An ADRT cannot be used to refuse basic care or situations that aim to facilitate the provision of this (e.g. a move into a care home). The refusal must relate to a specific medical treatment. For instance, refusal of artificial nutrition and hydration in the circumstances of a further stroke.

If the decision is not valid and applicable, then it cannot be used as a legal indicator of that individual’s decision. It can however be used as an indicator of their views and wishes as part of a Best Interests decision.

Healthcare professional’s responsibilities in relation to searching for ADRT’s are summarised in the following MCA Code Of Practice advice

9.56 – Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists. But if it is clear that a person has made an advance decision that is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment decisions will make this difficult.”

If a patient expresses a strong capacitated view regarding refusal of future treatment (perhaps as part of a Treatment Escalation Plan (TEP) consultation) then staff may support them with formulating an ADRT. There are no specific forms that must be used for making an ADRT. The link below offers one useful format.

<https://www.advancedecision.service.compassionindying.org.uk/>

**(d) Does anyone hold a valid Lasting Power of Attorney or Court Appointed Deputyship giving them authority to make this decision?**

**Lasting Power of Attorney ( LPA )**

This is a process whereby an individual (the donor) decides to grant decision making authority to another individual (the attorney). The attorney is a trusted other which can be a lay person (e.g. family or friend) or a professional (e.g. solicitor). LPA’s are devised to allow individuals to plan for a time in the future when they may lose capacity. It is important to note that in order to grant an LPA the donor must have had capacity in relation to setting up an LPA at some point in their life. An LPA cannot be set up once the person has lost mental capacity in regard to granting an LPA.

In order to become the decision maker an individual’s LPA paperwork must be registered with the Office of the Public Guardian (OPG). Confirming that this has occurred may occur in 3 ways:

1. Practitioners may request to see the relevant paperwork from the attorney or donor and be provided with copies. Successful registration may be seen by a dated OPG seal which will be applied to each page of the LPA documentation

ii) Completing an OPG100 and searching the OPG registers via the link below:

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1116079/opg100-find-out-if-registered-attorney-or-deputy_2022.pdf>

1. entering an LPA access code given to you by the donor or attorney:

[View a lasting power of attorney - GOV.UK (www.gov.uk)](https://www.gov.uk/view-lasting-power-of-attorney)

There are two types of LPA:

**Health and Welfare** –This gives the attorney decision making authority around; a) general welfare issues and b) consent / refusal to healthcare treatment. The attorney can only make decisions on behalf of the person once it has been confirmed that the donor lacks capacity in a specific area within the health and welfare domain. As with all Best Interests considerations an attorney can only make decisions that are within the individual’s choice. For example, if two residential homes were on offer following a discharge from hospital then the attorney would be the decision maker between these two. Conversely an attorney has no power to choose an option that is not available such as a 3rd care home that commissioning bodies are unwilling to fund under a justifiable public law rationale. In a similar fashion a health and welfare attorney cannot choose a treatment that is deemed not clinically appropriate or available. (e.g. An attorney cannot demand a person be 'for resuscitation' in situations where CPR has been deemed futile or that the medical burdens outweigh the benefits.) Of note is the fact that a health and welfare LPA is unable to make a decision to deprive the donor of their liberty. This authority lies with the Local Authority and the Courts.

**Property and Affairs** – This makes the attorney a decision maker regarding the donor’s finances and assets. Whereas a health and welfare LPA can only be used once the person has lost capacity a property and affairs LPA can be set up so that the attorney can make decisions when the person still has mental capacity. This is often chosen by donors who do not want the inconvenience of managing their financial affairs or who are struggling due to physical frailty. Examples of decisions that may come under the scope of a property and affairs attorney include i) the ability to sell the donor’s property to pay for care costs or ii) the ability to pay rent or bills for an individual in supported living.

LPA arrangements may be organised in specific ways and / or set up with caveats and restrictions. For example, more than one attorney can be appointed. If this is the case, then the donor must choose if the attorney’s act *jointly* (they must consult and agree before each decision) or *jointly and severally* (they can act independently of each other). In regard to Health and Welfare LPA’s donors must specify if they wish to grant authority to the attorney in regard to ‘life sustaining treatment’ decisions. In regard to Property and Affairs LPA’s a donor may choose to limit the attorney’s powers, for instance not giving authority for the sale of a property. In order to access this additional information practitioners will need sight of the LPA paperwork or specifically request the additional information via the OPG search referenced above. A standard OPG search will just confirm the presence or not of a registered LPA for a person.

Becoming an attorney places the individual in the role of the ‘decision maker’ as discussed above. Whilst lay attorneys do not have the same responsibilities as professionals in regard to recording their reasoning, they remain bound by the same Best Interests principles as practitioners would be. It is important that practitioners respect this legal authority where the donor has granted this to another. If however, practitioners have doubts as to the abilities of the attorney or concerns that they are not acting in the donor’s best interests then this must be pursued. This could be via the attorneys themselves or via referral to the Local Authority Safeguarding Adults Teams and / or the OPG Safeguarding Team (OPG130). The latter link is shared below. Referrals should not be made simply on the basis of disagreement with the attorney.

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1098288/opg130-raise-a-concern-to-opg_16_Aug_22_Tabbed.pdf>

**Enduring Power of Attorney (EPA)**

This is the power of attorney provision that predates the Mental Capacity Act (2005). Although no new EPA’s have been made since that date existing ones that have been registered remain valid. EPAs relate to property and affairs only and cannot make an attorney decision maker in regard to health and welfare. In the same manner as LPA’s above professionals should ask to see copies of the relevant documents or can search the OPG register.

**Court of Protection Deputies and Declarations**

Declarations - The Court of Protection may make individual ‘one off’ declarations on financial and welfare matters affecting people who lack or are alleged to lack capacity ( MCA Code of Practice, 2005 ). This could include declarations as to the person’s capacity status and / or what is in their Best Interests regarding a financial or welfare issue. This information is not available via an OPG search. In a health care context, the majority of cases will be brought by Trusts / ICB’s so the relevant paperwork should be available via professional routes.

Deputyship – The Court of Protection can appoint a deputy if there is a need to make ongoing decisions for an individual who lacks capacity. This route will often be the case if regular decisions need to be taken for a person, there is an identified person who wants to take on the role, and the person has already lost decision making capacity in the relevant domain. The Court can appoint lay deputies ( i.e. family members ) or professionals to act on behalf of individuals. Their powers to act are organised in a similar fashion to the LPA arrangements described above. That is to say that a deputy will work on a ‘property and affairs’ and / or a ‘personal welfare (including healthcare) basis. Within each deputyship the Court may set caveats and limitations on decision making which are appropriate to that person’s circumstances. If it is within the sphere of their authority the deputy would become the ‘decision maker’ on the issue at hand. Any concerns about deputies not acting in the person’s best interests should be dealt with in the same manner as concerns about LPA’s. Deputyships are recorded on the OPG register.

**(e) Does this decision need to be taken now?**

Section 4(3) of the Mental Capacity Act states:

S(he) (the assessor) must consider

1. whether it is likely that the person will at some time have capacity in relation to the matter in question, and
2. if it appears likely that (s)he will, when that is likely to be.

**(f) Detail the individual’s past and present feelings and wishes in relation to the decision. Document any relevant values and beliefs held by the individual and anything else you believe they would take into account if they were making the decision.**

Once the parameters of the decision have been set and the available options considered it is essential to start with the person themselves. The Mental Capacity Act at s6(1) states that the assessor must take into account “the person's past and present wishes and feelings” and at s6(b) “the beliefs and values that would be likely to influence his decision...”

If a person is able to express an (incapcitous) view it is essential that this is not discarded or ignored simply because they have been deemed to LACK capacity. ***Wye Valley NHS Trust v Mr B [2015] EWCOP 60*** reminds assessors that a finding of capacity is not an ‘off switch’ regarding their rights and freedoms. Decision makers still have a duty to take into account the individuals wishes and feelings with the caveat that under Best Interests the decision is shared with others. Other case law ***Cheshire West and Chester Council v PWK [2019] EWCOP 57*** also articulates an important point that the closer the individual is to having capacity the more weight their views should be given in best interest’s considerations. Note should also be taken of an individual’s behaviour. This is particularly important where individuals are unable to verbalise. For instance, a person may not be able to verbalise that they wish to leave a care setting, but their behaviour (trying an external door) may give some indication of their wishes. Considering past wishes must not be forgotten as a potential source of information. On occasion past wishes may be written down in the form of advance care plans, advance statements, or treatment escalation plans. Otherwise this information may be sourced from family and friends. Care must be taken however to distinguish between direct views of interested parties and determining what the person would have wanted from the accounts of interested parties.

Edith and Dr Bahir (GP)

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| Edith has dementia, lives in a care home and is due her Covid jab. She LACKS capacity regarding this so Dr Bahir speaks to her family as part of a Best Interests consultation. Whilst her daughter agrees with the need for a vaccination her son is against it. He expresses a strong anti-vaccination point of view. Dr Bahir attempts a conversation with Edith but unfortunately, she is unable to give a meaningful indication of her wishes either way and becomes distressed during the encounter. Dr Bahir speaks to the care home manager who mentions that Edith is always compliant with any nursing interventions at the home. He consults his GP record and can see that Edith has had her flu vaccination for the past 10 years and that these pre-dates her dementia diagnosis. He comes to the view combining past wishes and present behaviour that it is in her Best Interests to have the vaccination |

One difficulty often encountered is how to consult with a person within the context of a formal Best Interests meeting. Williams et al ( 2012 ) suggest best practice is to involve the incapacitated person at the meeting. If the person has a significant cognitive impairment or strong concrete views, then attendance at a meeting may cause distress to the individual and their family. It may also mean that a productive discussion may not occur. Decision makers should consider beforehand if any reasonable adjustments can be made to accommodate the person. If it is decided that this is not possible then the decision maker may consult with them separately.

Case law also draws a distinction between ‘substituted decision making’ and ‘best interests’ decisions’ ***Re G (TJ) (2010) EWHC 3005 (COP)****.* Practitioners are not required to make the actual decision the person would have made if they had capacity. Additionally Professionals and carers are not able to undertake an action that would place the person at significant risk of harm. Section 1(4) of the MCA states that “A person is not to be treated as unable to make a decision merely because he makes an unwise decision.” This does not mean however that a professional is obliged to carry out an unwise decision on the person’s behalf.

**(g) Details of those consulted / involved in this decision-making process:**

The Mental Capacity Act Code of Practice identified that the groups below should be consulted where it is *“practicable and appropriate”*.

5.49 ...the decision maker has a duty to take into account the views of the following people:

* + anyone the person has previously named as someone they want to be consulted
  + anyone involved in caring for the person
  + anyone interested in their welfare (for example family carers, other close relatives, or an advocate already working with the person)
  + an attorney appointed by the person under a Lasting Power of Attorney
  + a deputy appointed for that person by the Court of Protection

5.50 If there is no-one to speak to about the person’s best interests, in some circumstances the person may qualify for an Independent Mental Capacity Advocate (IMCA).

5.51 – Decision makers must show that they have thought carefully about who to speak to. If it is practical and appropriate to speak to the above people, they must do so and must take their views into account. They must be able to explain why they did not speak to a particular person …”

Other definitions of relationships such a Next of Kin or Nearest Relative (under the Mental Health Act) are only useful in terms of identifying an individual as an ‘interested party.’ These do not bestow any specific decision-making authority under the Mental Capacity Act nor give the input of those individual’s contributions any more weight in a Best Interest discussion.

The MCA Code of Practice identifies ‘family and close relatives’ as examples of relevant people to consult. Friends and other individuals who are not blood relations should also be considered by the decision maker if the individual wants them to be consulted or they declare an interest in the individual’s welfare. The Code goes onto state “In weighing up different contributions, the decision-maker should consider, how long an individual has known the person who lacks capacity and what their relationship is.” When consulting with interested parties it is important to separate out 2 questions. The first is to ask for their views and reasons as to the person’s Best Interests. The second is to ask what decision they think the person would have made and why.

As detailed above if there is *no interested party (family, friend, or previously appointed advocate) to consult* and the decision relates to one of the points below then a referral should be made for an Independent Mental Capacity Advocate (IMCA)

* + Where an NHS body is proposing to provide or withdraw serious medical treatment. (SMT referral)
  + Where an NHS body or local authority is proposing to arrange a change of accommodation to a residential / nursing home. (LTM Referral)
  + Where a person stays in a hospital for longer than 28 days
  + Where a person stays in a residential /nursing home for longer than 8 weeks
  + In care reviews when no-one else is available to be consulted
  + In adult protection cases. (Safeguarding Referral)

In regard to the final point an IMCA may be appointed where the person has family or friends to consult but there are Safeguarding Adults concerns present.

It is important to note that an IMCA does not assess capacity nor are they the decision maker regarding the Best Interest decision. Their role is to take on the role that a family member or friend would have and advocate for that person. They may also challenge the capacity assessment if they believe it to be inaccurate. The advocacy service within Somerset is currently provided by SWAN Advocacy and a referral may be made via the following link <https://swanadvocacy.org.uk/refer/somerset/>

**(h) Details of persons / organisations not consulted**

In respect of emergency or urgent Best Interest decisions it may not be practical to make contact with the interested parties. A wider group of individuals may be consulted at a follow up Best Interests discussion if the issue is one that is likely to re-occur.

Decisions about the *appropriateness* of consulting certain parties can cause difficulty for the decision maker. Decision makers *must not* *exclude* an interested party from the Best Interest discussion simply because they do not agree with the decision maker’s viewpoint. Genuine concerns however may arise when the decision maker believes the threshold for making a Safeguarding Adults referral has been met and interested parties are involved parties in ongoing Safeguarding Adults investigations. As discussed previously this should prompt the referral of an IMCA but their involvement would be alongside family not in place of it. The decision maker will need to decide what weight he places on the family members views considering factors such as; a) the link between the Safeguarding Adults concern and the decision being assessed or b) The status of the Safeguarding Adults investigation and if any conclusion has been reached (i.e. substantiated, partially substantiated, unsubstantiated, inconclusive).

James and Ebony (discharge nurse) - part 1

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| James has a moderate learning disability and lives at home with his mother. He is admitted to hospital in a malnourished state. He is deemed to LACK capacity regarding where he resides for his care and support. A safeguarding referral has been made in the community regarding James’ care by his mother who is visiting him regularly on the ward. An IMCA is appointed under the Safeguarding remit due to the allegations of neglect against his mother. Ebony contacts the local Safeguarding Team who state that the case is being looked at under S42 duties. They inform Ebony that there is no outcome yet as to their investigation. They share their preliminary view however that they do not think there is any malign intent on behalf of the mother. They believe that as she ages, she is struggling to adapt both in respect of her own needs and her sons. Ebony organises a round table best interests meeting with both James’ mother and the IMCA in attendance. |

1. **Summary of Best Interests decision-making**

One method of considering Best Interest decisions is to imagine a set of weighing scales in the context of the options identified in section b). The decision maker asks the group to consider the pros and cons for each option and then places them on their respective scale. This visualisation is useful to a point as there are other factors to consider. Different pros and cons may be afforded different weight meaning that the process requires more nuance than simply counting individual advantages and disadvantages.

A further factor to consider is the fact that different participants in the discussion will have a different emphasis on the weight that they place on individual factors. It has been discussed elsewhere in this document the tendency of professionals to give more weight to physical health and safety factors ***(GM; FP v GM and A Health Board (2011) EWHC 2778 (COP), Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905)***. This highlights the other essential point of Best Interests decision making. Best Interests is not just about physical health and safety but must also consider emotional well-being and psychological / mental health issues.

Perhaps the most succinct summing up of this approach to Best Interests decision making is given by Lord Justice Mumby (2010) who states;

*“The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person’s happiness. What good is it making someone safer if it merely makes them miserable?”*

Whilst Lady Hale at ***Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC67*** states that *“the purpose of the best interests test is to consider matters from the patient’s point of view”* ***Re M; ITW v. Z and Ors [2009] EWHC 2525*** statesthat whilst *“wishes and feelings will always be a significant factor … there may be elements of a case which are of magnetic importance.”* As already detailed above a Best Interests test is broader than simply attempting to make the decision the person would have made. Considered within Aintree’s statement that *“every patient, every case, is different and must be decided on its own facts.”* then it may be observed that there is a window to make a decision in opposition to a person’s expressed wishes.

The term ‘Best Interests meeting’ is in common use but neither Act itself or the MCA Code of Practice prescribes what form the discussion should take. A general rule of thumb to apply is that simple, less continuous, or less risky decisions could be undertaken via phone, email, or 1:1 meetings. More complex, contentious, or risky decisions are likely to require a face to face or virtual meeting. This is to facilitate an active discussion of the issue to try an achieve an agreement.

James and Ebony (discharge nurse) - Part 2

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| The Best Interests meeting takes place on the ward. In attendance are James’ mother, the IMCA, the ward sister, a social worker. James’ sister is calling in via Teams as she lives in Canada. Consideration of bringing James into the meeting is made but all parties agree that it would likely cause him undue distress. His input into the meeting is sought in advance via the IMCA. Ebony starts the meeting by giving a background and clarifying what the options are for James on discharge. These are i) return home in sole care of his mother, ii) return home with his mother and a package of care 3 times a day, or iii) move into a care home. James’s mother expresses a strong objection to the care home option. The IMCA confirms through his conversations with James his wish to return home with his mother, however James’s sister feels that the time has come for a move into 24 hour care. The group work through the pros and cons of each and eventually narrow the options to a move home with or without a care package, James’ sister acknowledging that a move into a care home would not be consistent with her brother’s wishes. James’s mother continues to state that she is able to meet her sons care needs despite evidence to the contrary. However, after the social worker clarifies what the support would actually look like, how it would be financed, and some of the benefits they may gain James mother’s opposition begins to weaken. She accepts that some support might be useful and agrees to a package of care for James on discharge. |

**(j) Document what action or decision has been reached in the person’s Best Interests**

The efficacy of best interests relies upon the agreement or consensus of all parties involved in the Best Interests discussion. If it has not been possible to achieve this then the onus is on the decision maker to contact the Mental Capacity Lead and/or seek legal advice. The ultimate arbiter where there is no agreement is the Court of Protection who are able to make definitive decisions regarding capacity and best interests.

**CASE LAW REFERENCES**

Please note that the brief descriptors underneath the case law references do not aim to summarise the entirety of the case law that they relate to. Instead they link to the points raised in the above guidance.

***Sheffield City Council v E {2004} EWHC 2808 (Fam)***

Bar for capacity assessment (do not set to high)

***Re G (TJ) (2010) EWHC 3005 (COP)***

Difference between substituted judgement and Best Interests

***The PCT v P, AH & the Local Authority [2009] EW Misc 10 (COP)***

Definition of use and weigh element

***LBL v RYJ {2010} EWHC 2665 (COP)***

Capacity relevant information – general (salient details)

***GM; FP v GM and A Health Board (2011) EWHC 2778 (COP)***

Capacity assessment including emotional factors in decision making

***Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905***

Capacity assessment including emotional factors in decision making

***CC v KK and STCC [2012] EWHC 2136, (COP) [2012] COPLR 627***

Available Options in capacity and best interests: Residence / Care context

***A,B & C v X, Y & Z [2012] EWHC 2400 (COP)***

*Macro* decision making (finances)

***Aintree University Hospitals NHS Foundation Trust v James {2013} UKSC*** 67

Available Options in capacity and best interests: Medical Treatment context

Purpose of Best Interests Test

***LBX v K, L and M [2013] EWHC 3230 (Fam)***

Capacity relevant information – residence/care/contact

***PC & NC v City of York Council [2013] EWCA Civ 478***

Reversal of capacity test (Is the inability linked to mental impairment)

***Cheshire West and Chester Council v P [2014] UKSC 19***

Acid Test, definition of deprivation of liberty

***LB Islington v QR [2014] EWCOP 26***

Capacity relevant information – tenancy

***LB Southwark v KA (Capacity to Marry) [2016] EWCOP 20***

Capacity relevant Information – marriage

***N v ACCG [2017] UKSC 22***

Limitation on available options (residence / care)

***The Hospital Trust v Miss V [2017] EWCOP 20***

Relevant Information – contraception

***CH v A Metropolitan Council {2017} EWCOP 12***

Misapplication of MCA Principle # 2 – supporting person to make the decision

***Royal Borough of Greenwich v CDM [2019] EWCOP 32***

Capacity - macro decisions / longitudinal assessment

***B v A Local Authority (2019) EWCA Civ 913***

Incompatible capacity outcomes

Using case law as a guide rather than rigidly adhering to criteria

***Cheshire West & Chester Council v PWK {2019} EWCOP 57***

Anxiety as a mental impairment & weight of incapacitated wishes

***London Borough of Tower Hamlets v Anor {2020} EWCOP 21***

Using case law as a guide rather than rigidly adhering to criteria

***Royal Bank of Scotland PLC v AB {2020} UKEAT***

Misapplication of MCA Principle # 1 – assumption of capacity

***London Borough of Tower Hamlets v PB [2020} EWCOP 34***

Linked decisions in context of alcohol misuse

***Sunderland City Council v AS and Others [2020] EWCOP 13***

Capacity Assessment, executive impairment, & real-world evidence

***A Local Authority v JB {2021} UKSC 52***

relevant information sex {current}

reversal of capacity test (functional before diagnostic)

***Pennine Acute Hospitals Trust v TM [2021] EWCOP 8***

Identification of Mental Impairment (under MCA)

***A NHS Foundation Trust v an Expectant Mother {2021} EWCOP23***

Agoraphobia as a Mental Impairment

***AC and GC (Capacity: Hoarding: Best Interests) [2022] EWCOP 39.***

Relevant Information – Hoarding

***North Bristol NHS Trust v R [2023] EWCOP 5***

Identification of Mental Impairment (under MCA)

Detail required in capacity assessment

***Warrington Borough Council v Y & Ors {2023} EWCOP 27***

Executive functioning and the MCA

***Wye Valley NHS Trust v Mr B [2015] EWCOP 60***

Value of views & wishes in Best Interests

***Re M; ITW v. Z & Ors [2009] EWHC 2525***

Factors of ‘magnetic importance’ in Best Interests decision making

**OTHER REFERENCES**

Mental Capacity Act (2005)

Mental Capacity Act 2005 Code of Practice [2007 final edition]

Learning from SARS: A report for the London Safeguarding Adults Board (July 2017).

Decisions relating to cardiopulmonary resuscitation – Guidance from the British medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (3rd ed, 1st revision) 2016

https://www.39essex.com/sites/default/files/2022-11/Mental-Capacity-Guidance-Note-Relevant-Information-for-Different-Categories-of-Decision-September-2022.pdf)

Applying decision-making capacity criteria in practice: A content analysis of court judgments

Nuala B. Kane, Alex Ruck Keene,Gareth S. Owen,Scott Y. H. Kim Published: February 5, 2021

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2. somicb.mentalcapacityanddol@nhs.net; [somicb.safeguardingandcla@nhs.net](mailto:somicb.safeguardingandcla@nhs.net) [↑](#footnote-ref-2)