Lancashire and South Cumbria Integrated Care Board

MENTAL CAPACITY ACT POLICY

This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite

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Purpose	This policy sets out the roles and responsibilities of the Integrated Care Board in respect of the Mental Capacity Act 2005 and the accompanying MCA Code of Practice. This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

Document control:		
Date:	**Version Number:**	**Section and Description of Change**
March 2025	V2.0	Revision of policy to reflect national and caselaw updates and an additional section on executive functioning.
October 2022	V1.0	Revision of policy to incorporate the LSC Integrated Care Board arrangements and to be incorporated within contract arrangements with all commissioned services.

Contents

For quick reference to any section in this policy, press ctrl and then click on the desired heading title.

1.0 Introductory

The Lancashire and South Cumbria Integrated Care Board (ICB) is required to take account of the principles within the Mental Capacity Act (2005) (MCA) and to ensure all services from whom it commissions services (both public, independent and voluntary and faith sectors) have a comprehensive policy relating to the MCA (2005) and if appropriate the Deprivation of Liberty Safeguards [1](DoLS) (2009). The function of this policy is to detail the roles and responsibilities of the ICB as a commissioning organisation and that of its employees. The MCA came into force in 2007 and provides a legal framework for the care, treatment and support of people aged 16 years and over, in England and Wales, who are unable to make some or all decisions for themselves. Anyone supporting people who lack mental capacity must have regard to the MCA. The MCA is accompanied by a statutory Code of Practice that explains how the MCA will work on a day to day basis and provides guidance to all those working with, or caring for, people who lack mental capacity.

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act, however, was introduced in April 2009.

The safeguards apply to people in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. In the event of it being necessary to deprive a person of their liberty the safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed. People can be deprived of their liberty in settings other than hospitals and care homes, such as supported living, but in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations in such circumstances should be made to the Court.

Important note:

As of March 2025, there is no current guidance or further updates for the new Mental Capacity Amendment Act (2019) and the implementation of the Liberty Protection Safeguards (LPS). The Liberty Protection Safeguards were intended to replace the Deprivation of Liberty Safeguards (DoLS). This was announced in a Mental Capacity Amendment Bill which passed into law in May 2019. Current guidelines continue.

This policy should be read in conjunction with NHS Lancashire and South Cumbria ICB Policies as detailed below.

- Domestic Abuse and the Workplace Policy

- Safeguarding Children and Adults Policy
- Freedom to Speak up Policy

This policy must also be read in conjunction with the Local Safeguarding Children Partnerships and Safeguarding Adults Boards Multiagency Policies and Procedures.

Lancashire Safeguarding Partnership - Lancashire Safeguarding Partnership Guidance for Safeguarding Concerns
lcc-adult-safeguarding-protocol-poster-handbook.pdf

Blackpool Safeguarding Partnerships

Cumbria Safeguarding Children Partnership | Cumbria Safeguarding Children Partnership

Blackburn with Darwen Multi- Agency Operational Policy and Procedures for Safeguarding Adults at Risk

1.1 Scope

This policy applies to all staff whilst performing duties on behalf of **NHS Lancashire and South Cumbria Integrated Care Board (LSCICB)**. This policy aims to ensure that no act or omission by the ICB as a commissioning organisation, or via the services it commissions, is in breach of the MCA or DoLS (2009) and to support staff in fulfilling their obligations. As with the wider MCA, LSCICB will wish to be assured that the rights of the population on whose behalf it is commissioning services are protected in relation to the safeguards. The ICB wish to be assured that people are not being deprived of their liberty unlawfully and as appropriate the protections that the safeguards offer are in place.

The MCA sets out who can and how to make decisions relating to care and treatment for those who lack capacity to make such decisions. The Act covers decisions relating to finance, social care, medical care and treatments, research and everyday living decisions, as well as planning for the future. The MCA protects organisations, providers, and families from liability, allowing necessary care and treatment to take place just as if the person who lacks capacity has consented to them and the action is legally in the person's best interests. Practitioners are required to:

- Observe the principles of the MCA
- Make assessment of capacity where it is reasonably believed that the person lacks capacity in relation to the matter in question

- Have a reasonable belief that the action taken is in the best interests of the person.

The legal frameworks set out below should be considered in the application of this policy.

- The Mental Capacity Act 2005 (Amended 2007 and 2019)
- The Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- The Mental Health Act (2003)
- The Human Rights Act (1998)
- The European Convention on Human Rights
- The Care Act (2014)
- The Children Act (1989) (2004)

1.2 Principles

The presumption of capacity should be the underpinning ethos of the interactions between health, social care and public sector workers whenever they are required to interact and/or build relationships with any member of the public. Individuals can make their own decisions unless they lack the capacity to do so, which must be proved by the person who is seeking to make the decision on the person's behalf. Capacity should only be assessed if there is a reason to doubt that the person is able to take a particular decision at a specific time; it does not relate to a particular diagnostic label.

In developing this policy, the ICB recognises that implementation of the MCA is a shared responsibility with the need for effective joint working between agencies and professionals. To achieve effective joint working, there must be constructive relationships at all levels, promoted and supported by the commitment of the chief executive officer, executive safeguarding leads, senior managers and board members to:

- Implement the MCA across their organisation
- Have clear lines of accountability within the organisation for work relating to MCA
- Undertake service developments that take account of the need to incorporate the MCA Into practice and is informed where appropriate, by the views of service users
- Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in relation to implementing the MCA
- Effective interagency working, including effective information sharing

1.3 Definitions

1.3.1 Mental Capacity

Within the MCA the term capacity relates to the person's ability to make decisions for themselves including consent to or refuse care or treatment. The Act provides a two-stage test for assessing a person's capacity and this must be used for each individual decision to be made and guided by the key principles of the MCA.

Five key principles when assessing capacity

- A person must be assumed to have capacity unless it is proven otherwise
- All reasonable steps must be taken to assist the person to make a decision
- Individuals have the right to make unwise decisions, even those others may consider eccentric
- All actions on behalf of those who lack capacity must be in their 'best interests'
- Any treatment should be done in the least restrictive manner of the persons basic rights and freedoms

Presumption of Capacity

The presumption of capacity is important; it ensures legitimate respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity to make the relevant decision, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way.

For further guidance refer to the link below.

Mental-Capacity-Guidance-Note-Codes-of-Practice-Update-February-2022.pdf

Two stage test

To help determine if a person lacks capacity to make a particular decision, the Act sets out a two-stage test of capacity.

The Supreme Court in A Local Authority v JB (2021) confirmed, that it is necessary to start with the second stage of the Code: i.e. whether the person is functionally able to make the decision.

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

Stage 1: requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.

Once the diagnostic test establishes that a person lacks capacity, a 4-stage functional test is undertaken to assess a person's ability to make the decision for themselves. It is more likely than not that a person will be unable to make a decision if they cannot do one or more of the following stages:

1. Understand the information about the decision (ensuring this is provided in the most accessible way relevant to that individual)
2. Retain that information in their mind (this does not have to be for a long period of time)
3. Use or weigh that information as part of the decision-making process
4. Communicate their decision (by talking, sign language, writing or any other means)

The burden of proof is on the assessor/decision maker to provide evidence that the person does not meet any of the functions above; and to prove that, on the balance of probability, the person lacks mental capacity to make the decision at the time it needs to be made. At times individuals may struggle to make decisions because of several factors unrelated to any impairment or disturbance that they may or may not suffer. These factors can be due to:

- Pressure, coercion, duress (Serious Crime Act 2015, Domestic Abuse Act 2021)
- Lack of sufficient information
- Information is not provided in an accessible format

In this situation, assessors/decision makers should ensure adjustments and support is offered to ensure that the person is enabled to make their own decision. On occasions a person may refuse to engage in an assessment of their mental capacity to make a specific decision. When this occurs, all efforts should be made to establish a rapport with the person to seek their engagement, and to explain the consequences of not making the relevant decision. Where this occurs, the person concerned must be informed that the professional will determine their ability to make a specific decision on the balance of probability, considering the information they already have about the person, their cognitive ability, diagnosis, and presentation.

1.3.2 Best Interests

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the 'decision maker'. It is the decision maker's responsibility to work out what would be in the best interests

of the person who lacks capacity. The Act does not define the term "best interest"; however, section 4 of the Act (supported by the Code of Practice sets down how to decide what is in the best interests of a person who lacks capacity in any particular situation.

There are two circumstances when the best interest's principle will not apply. The first is where someone has previously made an advance decision to refuse medical treatment while they had the capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests. The second concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent.

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour.
- All relevant circumstances should be considered when working out someone's best interests
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision if there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent
- Special considerations apply to decisions about life-sustaining treatment
- The person's past and present wishes and feelings, beliefs and values should be considered
- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy

1.3.3 Lasting Power of Attorney (LPA)

The MCA allows a person aged 18 and over, who has capacity to make this decision, to appoint attorneys to act on their behalf should they lose mental capacity in the future. The provision replaces the previous Enduring Power of Attorney (EPA).

Lasting power of attorney (LPA) is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. This gives them more control over what happens to them if they have an accident or an illness and cannot make their own decisions (they 'lack mental capacity'). A person must be 18 or over and have mental capacity (the ability to make their own decisions) when they make their LPA. A person doesn't need to live in the UK or be a British citizen.

There are 2 types of LPA:

- Health and welfare
- Property and financial affairs

A person can choose to make one type or both types.

1.3.4 Court Appointed Deputies

The MCA provides for a system of court appointed deputies to replace the previous system of receivership in the court of protection. Deputies can make decisions on welfare, healthcare, and financial matters as authorised by the court of protection. They are not able to refuse consent to life sustaining treatment.

1.3.5 Court of Protection

The Court of Protection has jurisdiction relating to the whole MCA and is the final arbiter for capacity matters. It has its own procedures and nominated judges. The MCA provides for a COP to make decisions in relation to the property, affairs, healthcare, and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges, and authority in relation to mental capacity matters as the High Court. It is a superior court of record and can set precedents (i.e., set examples to follow in future cases).

The Court of Protection has the Powers to:

- Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions
- Appoint deputies to make decisions for people lacking capacity to make those decisions
- Decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid; and remove deputies or attorneys who fail to carry out their duties and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid

The Court of Protection must be asked to make decisions relating to:

a. The proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS)

b. Cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person

c. Cases where there is a dispute about whether a particular treatment will be in a person's best interest

d. Proposed non-therapeutic sterilisation of a person who lacks capacity to consent (for example, for contraceptive purposes)

Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link: https://www.gov.uk/courts-tribunals/court-of-protection

There may be situations where it is necessary for the ICB to cooperate with or make an application to the court of protection. This will usually be where the ICB is funding care or treatment.

1.3.6 Advance Decision to Refuse Treatment (ADRT)

The MCA creates ways for people 18 and over, and able to decide in advance to refuse treatment if they should lack capacity in the future. An advance decision to refuse treatment that is not life sustaining does not need to be in writing, but the person must ensure the relevant professionals know what treatment is being refused. A decision refusing advance life sustaining treatment must be in writing, signed and witnessed with a clear statement of which treatments are being refused. Professionals must take all reasonable efforts to be aware of any advance decisions that exist and check their validity and that they are applicable to the particular treatment in question.

1.3.7 Independent Mental Capacity Advocate (IMCA)

An IMCA is an advocate appointed by the local authority or NHS body, in certain circumstances, to support a person who lacks capacity in the decision-making process. The decision maker must consider the views of the IMCA but is not bound by them. Advocacy promotes equality, social justice, and social inclusion. An IMCA is not a decision maker for a person who lacks capacity and has a role to support the person who lacks capacity and represent their views and interests to the decision maker, nor are they mediators between parties in dispute. Referrals to an IMCA MUST be considered when there needs to be a decision relating to serious medical treatment and where a long-term move to different accommodation is being considered

1.3.8 Mental Capacity and Young People

The Mental Capacity Act (2005) applies to all people 16 years of age and over in England and Wales and states that; young people aged 16 and over can consent to medical treatment, care, and provision of support. However, if there are concerns around the young person's capacity to consent or to make decisions then a Mental Capacity assessment should be completed under the Mental Capacity Act (2005).

This capacity assessment should be time and decision specific, and as such any assessments completed may require to be revisited.

When assessing capacity, consideration should be given to the vulnerability in terms of trauma, abuse, coercion or control, the young person may be subjected to/ have experienced, including cognitive and developmental age/ functioning. All concerns, assessments, actions taken, and decision making should be clearly documented in the records.

Where the MCA does not apply to young people aged 16-17

There are certain parts of the MCA that do not apply to young people aged 16-17 years. These are:

- Only people aged 18 and over can make a Lasting Power of Attorney, (LPA).
- Only people aged 18 and over can make an advanced decision to refuse medical treatment.
- The law generally does not allow people under 18 to make a will and the MCA confirms that the Court of Protection has no power to make a statutory will on behalf of anyone under 18.

In most situations, the legal framework of the Children Act 1989 supports the care and welfare of children under 18 years. However, two parts of the MCA apply to children under 16:

The Court of Protection can make decisions about a child's property or finances, (or appoint a deputy in order to make these decisions), if the child lacks capacity to make decisions within section 2(1) of the Act and is likely to still lack capacity to make these decisions when they reach 18 years of age.

The criminal offence of ill treatment or wilful neglect of a person who lacks capacity applies to children under 16 as no lower age limit is specified for the person caused harm/victim. If the child/young person has capacity this would be dealt with under safeguarding/criminal legislation.

Parental Responsibility and the MCA

Parental Responsibility (PR) relates to the "rights, duties, powers, responsibilities and authority which by law a parent has in relation to a child", (Children Act 1989). PR ends when the young person, ("child" under Children Act 1989), reaches 18 years of age or at an earlier age if ordered by the court.

Those with PR can make decisions on behalf of that child/young person that are deemed to sit within the zone of parental control.

- Is this a decision a parent should reasonably be expected to make?
- Are there any concerns the person with PR may not/be unable to act in the child/young person's best interests?
- Is the child/young person resistant to the outcome of the decision?
- How invasive is the proposed intervention/decision to be made?

The greater the resistance and the greater the intervention the less it would be reasonable to expect a person with parental responsibility to make the decision whether it is in the child's best interests.

Where there are issues around the mental capacity of the young person to consent to their arrangements for care and treatment, and the parents with PR are unable to consent on their behalf both these rights need protecting by the appropriate legal framework.

For further guidance re parental responsibility; Parental rights and responsibilities: Who has parental responsibility - GOV.UK (www.gov.uk)

For those services working with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families in becoming familiar with the powers and provisions within the Act is an essential part of transition work.

Families may choose to approach the Court to become a Court Appointed Deputy for welfare decisions or property and finance decisions. Information should be provided to assist with such applications.

There is an expectation that those providing services for 16- and 17-year-olds commence transition into adult services and MCA consideration/awareness with families and the child when the child is 14 years old.

It is important that parents/carers are aware of the changes to their role in decision making for their child/ young person. For decisions about health and welfare, the Mental Capacity Act applies to everyone over the age of 16 years

Transition from young people focussed to adult oriented services can cause considerable stress for families and carers. To reduce the stress, it is vital that transition planning is started early, at 14 years, and is central to any work that is undertaken with the young person and their family. It should centre on the views, wishes and aspirations for the future of the young person and their parents / carers. It is also essential that the services and support provided at the time of transition are seamless but also enable the young person to achieve greater independence.

1.3.9 Disputes

There may be occasions where there could be a disagreement or dispute as to what would be in the best interests of an incapacitated individual, for example between clinicians and family members. In the event of a dispute, staff should seek local resolution where possible and follow local safeguarding adult board procedures.

Consideration should be given to the points below in assisting the decision maker to resolve the dispute:

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

Where local resolution of a dispute is not possible despite all efforts of the decision maker, consider with line management and via the Designated Professionals for Safeguarding and MCA, whether a legal perspective should be obtained. This should take place before finalising any decisions to seek legal advice with a view to approach the Court of Protection. The Court of Protection has jurisdiction to resolve disputes.

1.3.10 Executive Functioning

Executive function can be described as the ability to think, act, solve problems including learning new information and remembering and retrieving what a person has previously learnt. It refers to skills that a person uses to manage everyday tasks like making plans, solving problems and adapting to new situations.

The three main skills are working memory, cognitive flexibility and inhibition control. Disorders of the mind or brain widely recognised to be associated with executive dysfunction include acquired brain injury (ABI), dementia, delirium, learning disability, ADHD, autism, addiction, mood disorder and personality disorder.

Terms such as ‘executive functioning’ and ‘executive capacity’ do not appear in the MCA itself, nor do they currently appear in the code of practice. However, the courts have recognised these concepts and referred to ‘executive functioning’ and ‘executive dysfunction’ in the relevant case law.

The MCA code of practice gives guidance on using or weighing information as part of the decision-making process and describes for someone to have capacity, they must have the ability to weigh up information and use it to arrive at a particular decision. Sometimes people can understand information, but an impairment or disturbance stops them using It and putting the decision into practice. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given.

“For example, a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore. Some people who

have serious brain damage might make impulsive decisions regardless of information they have been given or their understanding of it."

While the code does not use the term executive functioning, It is important to consider:

- Whether practicable support can be provided to a person experiencing difficulties with their executive functioning to enable them to make the specific decision in question

- Difficulty with executive functioning is not, by itself, evidence of a lack of capacity

- Awareness that people with executive functioning difficulties may overestimate their skills and abilities and underestimate their need for care and support or not be able to put the decision into practice

- Understand past behaviour and whether this demonstrates an inability to put into effect their stated intention

- Determine whether the person understands that there is a mismatch between what they say they will do and how they act when faced by concrete situations

- Consult with others, including family, friends and involved professionals, across the multi-disciplinary team about the person's ability to carry out their decision

- Clinical input may be required when assessing executive functioning, for example, from a clinical psychologist.

Further information can be found here

2.0 Roles and Responsibilities for implementation of the MCA

2.1 General Roles and Responsibilities of the ICB

1. Establish clear lines of accountability for implementation of the MCA, which is reflected in governance arrangements.
2. Secure the expertise of a lead for the MCA to support policy and training development
3. Ensure that the MCA is embedded into practice, and this is discharged effectively across the health economy through the ICB commissioning arrangements

4. Ensure that the ICB exercises a responsibility in ensuring service users receive treatment within the guidelines of the MCA Code of Practice
5. Ensure that MCA is identified as a key priority area in all strategic planning processes
6. Ensure that MCA implementation is integral to clinical governance and audit arrangements
7. The ICB oversee through governance arrangements that hospitals as managing authorities comply with DoLS legislation
8. Ensure that all health providers commissioned by the ICB have comprehensive policies and procedures for MCA implementation and Deprivation of Liberty Safeguards, and are easily accessible to staff at all levels
9. Ensure that all employees of the ICB have MCA training and competency appropriate to their role and responsibilities
10. Work in partnership with all health providers in achieving MCA training and competency appropriate to their role and responsibilities
11. Ensure that all contracts for the delivery of health care include clear standards for implementing the MCA; these standards are monitored thereby providing assurance that the MCA is being correctly implemented
12. Ensure that all health organisations with whom the ICB has commissioning arrangements have links with the local Mental Capacity networks and the work of the Local Safeguarding Adults Boards
13. Ensure that any system and process that includes decision making around individual patient activity (e.g. funding panel) clearly demonstrates compliance with the MCA. This includes ensuring that assessment of capacity is documented relating to the specific decision and any following decision is documented in line with the best interest process

2.1.1 Role of the Chief Executive Officer

The Chief Executive Officer (CEO) is accountable for Safeguarding and Mental Capacity Act implementation within the ICB. Delivery, discharge and assurance of statutory duties is delegated to Chief Nursing Officer (CNO) within the ICB structure. The Chief Executive is accountable for ensuring that the health contribution to safeguarding including mental capacity Act implementation is discharged effectively across the whole local health economy through Integrated Care Board commissioning arrangements

This role is supported through the Chief Nursing Officers portfolio and is led by the Director of Safeguarding. A safeguarding team is situated within the ICB model which incorporates the statutory safeguarding roles of Designated and Named Professionals and a complimentary skill mix team.

The safeguarding team has a responsibility to ensure the safe discharge of Mental Capacity Act duties within the ICB, assurance of compliance with

National Safeguarding Standards by the ICB itself and from those organisations from whom services are commissioned.

2.1.2 ICB Safeguarding Director with Responsibilities for MCA

1. Ensure that all service plans / specifications / contracts / invitations to tender etc. include reference to the MCA and MCA Deprivation of Liberty safeguards. Further guidance on standards is detailed in the Safeguarding children, young people and adults at risk in the NHS (2024).
2. Ensures that MCA is identified as a key priority area in all strategic planning processes.
3. Ensures that MCA is integral to clinical governance and audit arrangements.
4. Ensures the ICB co-operates with the local CSAPs and LSABs in relation to MCA.
5. Ensures that any system and processes that include decision making about an individual patient (e.g. funding panels) takes account of the requirements of the MCA this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act.

2.1.3 ICB Individual Staff Members

1. To be aware of patient groups who may require assessment under the MCA due to an impairment or disturbance of the mind or brain. Any treatment decisions that follow an assessment of capacity must be fully documented to ensure the best interest process has been followed.
2. According to role, undertake training (as appropriate), including attending regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the MCA.
3. Understand the principles of confidentiality and information sharing in line with the MCA.
4. All staff contribute, when requested to do so, to the multi-agency best interests' meetings when related to funding of placements / care and treatment decisions.

3.0 Implementation

3.1 Method of Monitoring Compliance

Healthcare providers will be required to complete the self-assessment Safeguarding Assurance Audit Framework which includes standards for MCA. As part of the monitoring of safeguarding arrangements for commissioned services, safeguarding standards are incorporated into the annual contract process. Assurance is provided through the ICB self-assessment based on the Safeguarding children, young people and adults at risk in the NHS (2024). ICB compliance against this policy will be monitored via the Safeguarding Assurance Group Dashboard on a quarterly basis. Exceptions or non-compliance will be reported via appropriate governance routes. Additionally, learning applied from safeguarding adult reviews are reviewed via ad hoc audits; this forms part of the assurance of sustained implementation.

3.2 Breaches of Policy

This policy is mandatory. Where it is not possible to comply with the policy or a decision is taken to depart from it, this must be notified to the ICB so that the level of risk can be assessed, and an action plan can be formulated (see section 3.3 for contact details).

3.3 Contact Details

LSC ICB	Telephone Number	Email contact
Lancashire and South Cumbria	0300 373 3600	Lscicb.safeguarding@nhs.net

4.0 Reference Documents

In developing this Policy, account has been taken of the following legal frameworks, statutory guidance and case law updates:

A Local Authority V JB (2021) UKSC 35

Department for Constitutional Affairs (2007) MCA 2005: Code of Practice. TSO: London

Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to Supplement MCA 2005. London TSO The stationery Office, Children's commissioner (2004) Children Act 2004, London TSO

HM Government (2005) The Mental Capacity Act

HM Government (2019) The Mental Capacity Amendment Act

HM Government (2014) The Care Act

HM Government, The Children Act (1989) (2004)

Safeguarding children, young people and adults at risk in the NHS (2024)

NICE National Institute for Health and Care Excellence: Decision-making and mental capacity overview

Carrying out and recording Capacity Assessments – 39 Essex Chambers March 2023

Parental rights and responsibilities: Who has parental responsibility - GOV.UK (www.gov.uk)

5.0 Appendices

5.1 Appendix 1: Checklist for practitioners applying the Mental Capacity Act

Checklist for practitioners applying the Mental Capacity Act

5 Principles: Apply them in practice

1. Assume the person has capacity unless proven otherwise.
2. Enable capacity by assisting the person when making a decision (use visual aids / written words / interpreters etc. as appropriate).
3. If a person with capacity makes an unwise or eccentric decision this must be respected.
4. If a person lacks capacity treatment decisions must be made in the person's best interests (follow the statutory checklist).
5. The treatment given should be the least restrictive option to the person's rights and freedoms.

Ref Code of Practice Chapter 2

Enabling Capacity: Have you,

- Been clear about what decision needs to be made, define it clearly and concisely (this helps in other aspects of the Act).
- Made every effort to enable the person to make the decision themselves, by being flexible and person-centred.
- Provided information about the decision in a format that is likely to be understood including information relating to any alternative options.
- Used a method of communication/language that the person is most likely to understand.
- Made the person feel at ease and given consideration to what is likely to be the most conducive time and location for them to make the decision.
- Considered if others can help the person understand information or make a choice.

Ref Code of Practice Chapter 3

Assessing capacity:

Does the person have an impairment or disturbance in the functioning of the mind or brain? (Temporary or permanent)

If yes practitioners must complete the 4-part functional test. Can the person….

1. understand the information relevant to the decision?
2. retain the information long enough to make a decision?
3. weigh up the consequences of making the decision?
4. communicate their decision by any means?

If the person fails to demonstrate ability in any of the four areas, they would be deemed as lacking capacity to consent to or refuse that specific decision.

Ref Code of Practice Chapter 4

Decision Maker: Have you,

- Identified the decision maker ?
- Identified if the person has a registered Lasting Power of Attorney (LPA) or a court appointed deputy (CAD) for personal welfare who can consent or refuse treatment.
- Considered if decision can be delayed till the person regains capacity

Ref Code of Practice Chapter 5; 7 and 8
IMCA: Does the person require an Independent Mental Capacity Advocate? Ref Code of Practice Chapter 10
Deciding Best Interests: have you • Encouraged participation • Not discriminated or been driven by a desire to bring about death • Considered person's views and wishes • Promoted the person's rights • Identified if the person has an Advance Decision to Refuse Treatment (ADRT) that is valid and applicable • Identified and spoken with family friends or others to be consulted • Considered all relevant factors • Reviewed the risks and benefits of the proposed procedure and its alternatives including not providing treatment. (options appraisal) • Reviewed and weighted all the evidence considering medical social welfare emotional and ethical aspects • Arrived at a decision • Communicated your decision and rationale • Put in place steps to implement the decision that is least restrictive Ref Code of Practice Chapter 5
Restraint: Restraint is use force – or threaten to use force – to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. Does what you are proposing fall within the definition of restraint? Is the restraint necessary to prevent harm? Is the level of restraint proportionate to the likelihood and severity of harm? You cannot deprive of liberty without lawful authorisation Ref Code of Practice Chapter 6
Protection From Liability: Follow the Act; document it and you will receive protection from liability Ref Code of Practice Chapter 6

5.2 Appendix 2: Sample Mental Capacity Assessment Tool

5 KEY PRINCIPLES OF THE ACT

- Assume the person has capacity unless proven otherwise
- Do not treat the person incapable of making a decision unless all practicable steps have been tried to help them
- A person should not be treated incapable of making a decision because their decision may seem unwise
- Always make decisions for people that lack capacity in their best interests

- The decision you make for that person must be the least restrictive option available

Assessment of Capacity

NAME OF PERSON BEING ASSESSED:		xxxxx			
DATE OF BIRTH	xxxxx	DATE	xxxxx	TIME	xxxxx
ADDRESS: xxxxxxxxx					
DETAILS OF THE DECISION TO BE MADE: **(The capacity assessment is ALWAYS time and decision specific)** To ascertain if P can understand*:(these are possible examples)* • their assessed care and support needs and the consequences of not having the current levels of support. • Their place of residence • The use of social media • The specific decision to be made.					
THE FOLLOWING STEPS HAVE BEEN TAKEN TO SUPPORT THE PERSON TO MAKE THE DECISION IN QUESTION (***refer to MCA 5 principles***)*:* • Prior to the capacity assessment xxxxxxx (nurse assessor/practitioner) liaised with the care provider to ascertain if a face-to-face meeting or Teams call would be appropriate and to also plan the specific questions to ask. • Identify who has been allocated to support P and their relationship to them including how long they have known them. • Identify what steps you have taken prior to the meeting to gather supporting information including who you have spoken to which may include family/care staff/deputies/LPAs. • Explain how P presented on the day of the assessment (relaxed/alert/calm/responsive) • Identify what aids were used during the assessment including visual aids, pictures, flash cards etc. • A capacity assessment took place on xxxxxxx. This was completed virtually/in person.					

ASSESSMENT CRITERIA		
DOES THE PERSON BEING ASSESSED HAVE AN IMPAIRMENT OF OR A DISTURBANCE IN THE FUNCTIONING OF THE MIND OR BRAIN	YES	NO
IF ***NO*** THE PERSON SHOULD BE CONSIDERED TO HAVE CAPACITY IF ***YES*** GIVE DETAILS (*Including where possible details of when and by whom a diagnosis was made*) AND COMPLETE SECTIONS A TO E BELOW *Examples may include severe learning disabilities, Autism, Brain injury, Alzheimer's, Dementia etc.* *This list is not exhaustive.*		
A: CAN THE PERSON BEING ASSESSED ***UNDERSTAND*** THE INFORMATION RELEVANT TO THE DECISION	YES	NO
GIVE DETAILS *(THIS IS JUST AN EXAMPLE AND NOT TO BE COPIED)* P was asked basic questions using an accessible format including asking if they know where they live, if P is happy living where they are, what help is needed and what could happen if they did not have the support from care staff? P's response when asked what it is like living at xxxxxxx were, 'Exciting – its good', further elaborating that the things they like about living at xxxxxxxxx are the food, day trips and care staff. When asked if there was anything that they didn't like about living at xxxxxxxxx they replied xxxxxxx. P was asked questions in relation to the care and support from care staff: • Do you need any help managing your money? Who helps? • Do you need help with personal care? Who helps you? • Do you have any medical conditions that staff help you with? • What do you like to do during the day? • Can you tell me what help you need when you go out? • Do you need any other help when you go out? • Do you need any help with cooking or preparing snacks? • Do you need any help with keeping your bedroom clean and tidy or with washing your clothes? • If you had no help do you know what could happen? Repetition of the questions was again used as below to clarify P's understanding of their care and support: • Can you tell me what support you need to help you stay safe at home? • If you didn't have staff during the day/overnight what could happen? • Do you need any help with your medication? If you didn't have any help what could happen?		

- If you had no staff what could happen?
- If you went out without any support, what do you think could happen?

P's responses indicate that they have/do not have a good understanding of their day-to-day care and support needs.

- Is P able/not able to consistently demonstrate a clear understanding of their care needs,
- Is P able/unable to understand and weigh up risks and consequences?
- Is P able/unable to fully understand the level of support required to ensure that their needs are safely met.

B: CAN THE PERSON BEING ASSESSED ***RETAIN*** THAT INFORMATION	YES	NO

GIVE DETAILS *(below is an example)*

P does/does not appear to be able to fully retain information in relation to the decision, in particular P appears able/unable to fully understand and retain information regarding the risk and consequences of not having the assessed level of support that is provided.
P appears to experience difficulties making more complex decisions and as such is reliant on their support staff/family to advocate on their behalf dependent on the decision to be made and to also educate and guide them.

C: CAN THE PERSON BEING ASSESSED USE OR ***WEIGH*** THAT INFORMATION AS PART OF THE DECISION-MAKING PROCESS	YES	NO

GIVE DETAILS *(below is an example)*

It appears that P does/does not have the capacity to weigh the information relating to the decision.
It is evident from meeting with P and consulting with family and the care provider and reading documented information that P is unable to consistently understand, retain and therefore weigh up their support needs, in particular the risks and consequences of not having the current levels of support P is assessed as needing.

D: CAN THE PERSON BEING ASSESSED ***COMMUNICATE*** THEIR DECISION, WHETHER BY TALKING, USING SIGN LANGUAGE, GESTURES OR ANY OTHER MEANS	YES	NO

GIVE DETAILS *(below is an example)*

P can verbally/non-verbally communicate their day-to-day needs, views and wishes using audio/visual aids however may experience difficulties with more complex decisions.

IF THE ANSWER TO ANY OF THE QUESTIONS AT A-D ABOVE IS **NO** THE PERSON LACKS CAPACITY TO MAKE THAT PARTICULAR DECISION	
E: EXPLAIN WHY THE PERSON BEING ASSESSED IS UNABLE TO MAKE THE SPECIFIC DECISION BECAUSE OF THE IMPAIRMENT OF, OR DISTURBANCE IN THE FUNCTIONING OF, THE MIND OR BRAIN. *(Below is an example)* P has a diagnosis of xxxxxxxxxxxxx, which appears to impede on their cognition and ability to fully process and understand information. As a result, P appears unable to understand more complex concepts and is unable to understand risks and consequences of not having the current level of support. In my professional opinion P lacks the capacity to fully understand and therefore weigh up and retain information in relation to *(include the specific decision in here)* It is unlikely that P's condition will improve significantly.	
IN MY OPINION: ***P DOES NOT HAVE THE CAPACITY TO MAKE THE ABOVE DECISION***	
If the person is assessed as not having capacity to make this decision; you must consider the best interests check list before deciding what is in the person's best interest	
SIGNED	DATE
NAME IN CAPITALS:	
JOB TITLE:	

5.3 Appendix 3: Useful resources

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLs) Resource page - Lancashire Safeguarding Adults Board

Mental Capacity Act 2005 - resources | Cumbria Safeguarding Adults Board

How to carry out Mental Capacity Assessments

5.4 Equality and Health Inequalities Impact Risk Assessment (EHIIRA)

This policy has been reviewed March 2025 in line with Equality and Health Inequalities Impact Risk Assessment requirements and approved on 8 November 2022. A copy of the EHIIRA is available on request