



Mental Capacity Act

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What is the MCA and what does it mean?

The Mental Capacity Act (MCA) 2005 came into force in 2007. Its aim was to protect and restore power to people who may lack capacity to make certain decisions, due to the way their mind is affected by illness, disability, drugs or alcohol.

It is a law which applies to everyone aged 16 and over, regardless of their ability.

The MCA states that:

- Everyone has the right to make his or her own decisions.
- Individuals must be supported to make decisions for themselves.
- Just because someone makes a decision that is deemed “unwise” by others, they should not be treated as lacking the capacity to make that decision.
- Where someone is judged not to have the capacity to make a decision (following a capacity assessment) that decision can be taken for them, but it must always be in their best interests.
- Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms possible, but still provide the appropriate treatment and care.

In 2005, post-legislative scrutiny of the Mental Capacity Act by the House of Lords select committee concluded that more work was needed to embed MCA principles within everyday practice. A number of recommendations were made to improve the uptake of the MCA. Several projects have been running across the country to support the achievement of these recommendations and to date a number of key achievements are reported.

These include:

- Frontline training of staff including GPs on the processes and statutory duties.
- Increased numbers of best-interest assessors and development of tools to support staff.
- Patients and citizens consulted to understand how being subject to safeguards felt.
- Video newsletters and good practice guides for staff on communication have also been developed.

Group working to prevent MCA delays causing suffering

LeDeR reviews have highlighted a number of emerging themes and ongoing issues which clinicians and services need to urgently address to prevent further deaths.

Themes coming out of completed reviews include:

- Documentation around mental capacity assessments and best interest decision making is sometimes missing or poorly recorded.
- Delay or absence of the use of mental capacity assessments and best-interest decision-making.
- There is a lack of understanding of roles, responsibilities and competence in discharging the duties placed on professionals under the Act.
- The issues seem to be greater when people required urgent care within acute hospital settings.

These themes have resulted in:

- Delays in diagnosing and treating serious medical conditions.
- Delayed, or absent, end of life care planning.
- None existent, or poor, pain management.
- Urgent / proactive treatments not being delivered in line with clinical guidelines and pathways. These include blood tests, x-rays, scans, intravenous therapy and surgical interventions.

The consequences are that people with learning disabilities are encountering delays in diagnosis and treatment of serious medical conditions. This could increase suffering, have long-term implications on their health, wellbeing and quality of life, and ultimately could lead to death.

NHS England’s Learning Disability Programme set up a LeDeR Learning into Action Group to look at issues relating to the MCA. The group is made up of experts by qualification, professional experience and lived experience.

The group has developed literature and guidance to support quality improvement and enhance compliance with the MCA within secondary care.

It has a specific focus on the issues around assessing capacity and best-interest decisions for deteriorating patients who have learning disabilities.

The group is also attempting to raise the profile of the MCA by increasing healthcare workers’ confidence and competence when supporting a patient with learning disabilities. It also wants to develop the sharing of good practice.

Guidance sheets for people with learning disabilities, families, paid carers and professionals are currently being worked on by the group.

They include:

- A family carer grab guide on the MCA and focused on acute hospital care.
- Information and guidance for staff about how to support family carers.
- A grab guide for acute hospital staff on how to work within the MCA when decisions need to be made quickly but don’t sit under the “doctrine of necessity”.
- A video aimed at developing hearts and minds by showing how empowering the use of MCA can be.

The aim of this work is to complement existing information and requirements of organisations in relation to legal obligations under the MCA.

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Bringing the MCA to life using real-life cases in training

The named doctor for safeguarding adults took on responsibility for MCA training in primary care in the East Riding of Yorkshire CCG shortly after the House of Lords post-legislative scrutiny.

By the time the LeDeR programme was operational, the CCG had already held a protected time-for-learning event for all GPs as well as in-depth training for GP MCA leads within individual practices.

Real-case training

Reflecting on this training made the team realise that to embed this work further we needed to use real cases, suitably anonymized, to bring the MCA to life.

The GP Annual Learning Disability Health Check training has been an ideal forum to demonstrate how poor use of the MCA in these cases has had seriously detrimental consequences for patient care.

A typical case involving delay in the best-interest process illustrated how good practice could have produced a very different outcome.

In one example, a patient needed a brain CT scan. This was delayed for some weeks as the wrong people were invited to the initial meeting, so no decision was possible. The GP had not been invited, nor their opinion sort, so the patient’s medical needs and the scan technicalities were not considered.

The second meeting was delayed because of the holiday period. The patient died before the scan could be done with a condition that was potentially treatable.

The learning outcomes demonstrated in teaching were that appropriate professional opinions are vital and that a process— not a meeting— is required.

At a second event we requested speakers to consider the MCA in their presentations. The theme for the afternoon was *bowels*, a seemingly innocuous condition but one which can lead to death in people with learning disabilities.

The case of Richard Handley, who died of constipation, was discussed. We considered what a capacity assessment during a GP visit would look like, to ensure patients know how to take medication correctly.

The bowel screening service discussed the practicable steps they could take to help those with learning disabilities understand the process of endoscopy, including the use of easy-read information and supported appointments.

A specialist speech and language therapist gave tips for helping with communication to aid capacity assessments surrounding a simple examination procedure.

Whole-team approach is key

In the CCG, the protected time-for-learning events are attended by all primary care staff. Administrative staff who organise appointments attend alongside nurses and doctors. This whole-team approach is important.

The MCA Learning Disability Capacity Act Framework, does not appear to consider all the issues facing primary care workers.

Staff of a large practice were asked to note down any incidents over the course of a week where they thought further training in this area would be helpful.

Based on this output, we created a presentation for delivery to reception and health care assistants. This was trialled at two practices and feedback noted. This is now due to be delivered CCG-wide.

Topics addressed include capacity assessments such as ‘Does the patient understand when and where their appointment is?’; how to support the doctor, or nurse, gathering information for a best-interest process; and the importance of advance decisions to refuse treatment being sent with the patient to secondary care, if they have one.

Good use of the MCA relies on primary care taking the initiative and a whole-team approach.

Making training clinically relevant and allowing for discussion and practice of capacity assessments has really given the MCA meaning.

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Developing a web-based MCA assessment tool

The Mental Health Foundation MCA review in 2010 found that ‘risk averse’ and ‘paternalistic’ health and social care practice had prevented the MCA from empowering vulnerable adults to take decisions for themselves.

It concluded that more than half of health and social care professionals were failing to comply with the MCA’s requirements when conducting assessments of capacity.

Within Surrey and Borders Partnership NHS Foundation Trust, CQC feedback in 2015 concluded most members of staff were aware of the need to assess capacity and the need to conduct best-interest meetings, where appropriate.

But it found that the recording of decision-specific capacity assessments were not always taking place.

The CQC also said it could not see evidence of how people’s capacity had been enhanced.

What was wanted

To develop a method of recording MCA assessments which ensured that factors which affected capacity are considered and recorded; guided professionals in the assessment process; and produced an immediate written record of the assessment.

What happened

The team originally worked with some students from University College London Computing Faculty to develop a prototype.

This presented some ideas of what was wanted and enabled the trust to apply to the Nurse Technology fund for funding to develop the assessment tool. The team was successfully awarded £85,000 for the development process.

The tool can be accessed anywhere it is needed. It guides the member of staff through the mental capacity assessment process, ensuring that the staff member carefully considers all the aspects required in a thorough capacity assessment. The staff member types directly into the tool, and at the completion of the assessment a PDF report is instantly produced which can be uploaded to the person’s records.

Once the tool was ready an implementation and evaluation plan was developed. The team’s research assistant met with staff either individually, or in groups, to complete the pre-use questionnaires looking at their knowledge of MCA assessment; their confidence; and their satisfaction with their current method of assessment.

Staff were then shown how to use the assessment tool. Once people had used it, they were contacted again to repeat the questionnaire.

How it has been used

More than 300 staff working in health and social care within the trust’s learning disabilities division have been trained to use the tool, and 104 people have used it to carry out mental capacity assessments.

In total, the tool has been used to carry out more than 2,000 assessments of capacity with people with learning disabilities.

These have included assessments of capacity for health issues, including: surgery, radiotherapy, sedation before dental surgery, flu jabs, medication, having medical investigations; and social care issues, including: consent to photographs being taken, managing finances, sharing their information, activities and holidays, use of a room monitor.

What have we found

Feedback from staff members has been very positive. There has also been a significant increase in staff knowledge, confidence and satisfaction shown from the repeat questionnaires. In addition, the CQC has commented positively on the output from the tool in subsequent inspections.

What next

The trust is now in position to share the tool for other organisations to use. The tool is available at: www.github.com/sabpnhs/mcatool

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Briefing for Carers poster

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BRIEFINGS FOR CARERS
THE MENTAL CAPACITY ACT 2005

What is the problem?
Having mental capacity means being able to make your own decisions. Sometimes people with learning disabilities have decisions made for them, even though they could have made, or contributed to, the decision themselves.

What is the Mental Capacity Act 2005?
The Mental Capacity Act 2005 (MCA) affects people who are aged 16 and over, and living in England and Wales. It tells us:

- What to do to help someone make their own decisions about something
- How to work out if someone can make their own decisions about something
- What to do if someone cannot make decisions about something sometimes.

The key principles of the MCA

1. Start off by thinking that everyone can make their own decisions.
2. Give people all the support you can to help them make decisions for themselves.
3. If a person is able to make a decision for themselves, you should not stop them just because you think it is a bad decision.
4. If someone is not able to make a particular decision, it must be made in their 'best interests' - there is formal process for this.
5. If you are doing something or deciding something for another person that is in their 'best interests' you must try to maximise their freedom and rights as much as possible.

What does this mean for carers?
You might need to **assess capacity** where a person is unable to make a particular decision at a particular time. You must not assume they cannot make the decision just because they have learning disabilities, or they haven't been able to make similar decisions in the past.

The MCA says that a person is unable to make their own decision if they cannot:

- understand information given to them or
- retain that information long enough to be able to make the decision or
- weigh up the information available to make the decision or
- communicate their decision in any way.

You must help them as much as you can with this.

If someone does not have the capacity to make a decision for themselves, check if they have a **decision-maker**. This would be if they have a Lasting Power of Attorney, an advance decision to refuse treatment, or if they have a Deputy. If so, they would make the decision.

Otherwise, others must decide what would be in the person's **best interests**. To work out what is in a person's best interests there is a checklist (below).

The more important the decision (e.g. about life-saving treatment) the more formal the decision-making process should be.

Always remember to fully record the decision-making process, the decision made, and its outcome.

Best Interests Checklist

- Will the person be able to make the decision themselves sometime in the future? If so, could the decision wait?
- What are the wishes of the person?
- What are their beliefs and values?
- What other factors should be considered?
- What do other people who know the person well think would be in their best interests?
- What would be the least restrictive option?

